EFFECTIVENESS OF REIKI THERAPY ON DEPRESSION AMONG GERIATRICS IN SELECTED OLDAGE HOMES AT MADURAI

BY

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A dissertation submitted to the Tamil Nadu Dr. M. G. R Medical University, Chennai.

In partial fulfillment of the requirements for the degree of Master of Science in

MENTAL HEALTH NURSING

UNDER THE GUIDANCE OF

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OCTOBER–2017

A dissertation submitted to

The Tamil Nadu Dr. M.G.R. Medical University, Chennai.

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Master of Science in Nursing, April – 2017

CERTIFICATE

This is to certify that the dissertation entitled **"EFFECTIVENESS OF REIKI THERAPY ON DEPRESSION AMONG GERIATRICS IN SELECTED OLDAGE HOMES AT MADURAI"** is a bonafied work done by **ANDREW SOLOMON.M,** C.S.I. Jeyaraj Annapackiam College of Nursing, Madurai, submitted in partial fulfillment for the degree of Master of Science in Nursing.

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A STUDY TO EVALUATE THE EFFECTIVENESS OF REIKI THERAPY ON DEPRESSION AMONG GERIATRICS IN SELECTED OLDAGE HOMES AT MADURAI.

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ACKNOWLEDGEMENT

I praise and offer my sincere thanks to God Almighty for giving me strength and abundant blessing throughout my career.

Its my great privilege to take this moment to show gratitude to my parents, teachers, friends and relatives who made this thesis the successful one

'Joy is thankfulness'

'Gratitude is not only the greatest of all virtues but the parent of all others'

I can't explain my gratitude in words but it's the opportunity for me to express my sincere indebtedness to renowned institution **C.S.I Jeyaraj Annapackiam College of Nursing** for giving me a opportunity to do my post graduate in nursing.

I wish to express my gratitude and sincerity to our college Principal **Prof.Dr.C.Jothi Sophia,M.Sc (N).,Ph.D.,** for her support in the successful completion of the research work. I convey my heartfelt thank to **Prof. Mrs. Merlin Jeyapaul M.Sc(N)., Ph.D.,** Vice Principal for her support study and valuable opinion during my research.

At the moment of accomplishment I want to extend my gratitude to my research guide **Prof. Mrs. Jancy Rachel Daisy M.Sc(N)., [PhD].,** This work would not have been made possible without her guidance support and encouragement. She used to review my thesis progress, give her valuable suggestions and made my thesis worthy. I owe my sense of gratitude at this moment to her and I thank her for making me what I am today.

I would like to extend my heartfelt gratitude to **Mrs. Joy Christy M.Sc(N).,** lecturer, Co-guide for her constant encouragement and scholastic suggestions throughout the study.

I extend my gratitude and grateful acknowledgement to my class co-ordinator **Prof. Dr. John sam arun prabhu M.Sc(N)., Ph.D.,** and **Prof. Mrs. Esther M.Sc (N)** Joint Co-ordinator for their constant help, moral support, detailing about research process and encouragement to finish this study successfully.

In my first experience in the clinical research I thank **Dr. Charles Medical director and Mrs.Mirabel M.Sc (N)., Nursing Superintendent of Christian mission hospital** for their great support and encouragement who permitted me to give the interventions for the elderly people in his esteemed institution.

My sincere gratitude and thankfulness to the **inmates of Inba illam, Christian Mission Geriatric Home and Christian Seva Trust** for their patience co-operation throughout the study without whom I cant finish my thesis successfully.

I extend a special thanks to **Dr.Arun Prassana, Dr. Rajamani, Dr. Jessie metilda**, **Mr.Ebenezer Devavaram** for their valuable guidance and support on content validation.

I extend a special thanks to **Mrs.Angelin Manova,** Librarian, C.S.I. Jeyaraj Annapackiam College of Nursing, and the Librarian of Dr.MGR Medical University, Chennai and CMC, Vellore for their help in locating appropriate search material. There is no words to express my virtue of gratitude to my family especially to Mydad and mom **Mr. G. Marimuthu, Mrs. K. Selvarani** and my brother **Mr. Arun Solomon** for their endless love and supporting me financially in studies. I want to extend my heart full thanks to my maternal uncle and aunty **Mr. K. Deva Suthakar Pandian, Mrs.B.Dollis** for their prayer and blessings as well as in designing my career in a beautiful way.

I want to extend my special thanks to my aunt **Mrs.Caroline Jebavathy** for helping me in Tamil translation of my research tool.

I want to express my heartfelt gratitude to my brother **Mr.Allwin Mabes Raj** for his effective guidance in the analysis chapters & the encouragement, support given by them made this research to greater heights.

I want to extend my gratitude to **Mr.Rajkumar Franklin** and **Mr.Samuel Prabhu** for helping me in typing my thesis works.

I want to extend my gratitude to my friend **Mr.Allen Retna Stebi, Mr.Allan Samuel, Mr. Deepak Stephen** for their timely help, who spare their valuable time and put their efforts and made this research as a complete one.

Last but not least I want to express my gratitude to my friend **Ms. Jemitta Shan** who rendered her valuable time and effort during my research work is unforgettable one

I submit my deepest gratitude to all persons who rendered their valuable time and efforts either directly or indirectly in my research work.

Above all I thank **Lord Almighty** for giving me strength, sustaining in my hard times, without him I am nothing and he who made this journey as an unforgettable and joyful one in my life.

ABSTRACT

Introduction

The old age is an integral part of human life. It is the evening of life. It is unavoidable, undesirable, unwelcome and problem ridden phase of life. But it is really interesting to note that everybody likes to live a long life, but not to be old. It is ironical that however undesirable the old age that is bound to life. A man is compelled to go through the pains and pleasure of this age as like other phases in life, before making exit from this mortal world. Reiki therapy may help restore a person's overall sense of balance, both in the mind and the body. This may help to improve the person's mood and help him or her to overcome feelings of guilt and/or sadness. . However there are inherent difficulties in assuming from these studies that Reiki therapy for depression is an effective treatment with the general adult population.

Research hypotheses were formulated to find the significant difference between control and experimental group. The review of literature was done and organized based on Studies related to ageing and level of depression among geriatrics. Studies related to effectiveness of Reiki therapy on the level of depression among geriatrics. The conceptual framework of this study was based on The conceptual framework of this study was based on" modified J.W Kenny's open system model".

Methodology

The research design adopted for the study was quasi pre-test post test control group design. The study was conducted at selected Geriatric home, Madurai. The samples selected were 60, of which 30 samples were allotted in the experimental group and the remaining 30 were in the control group. The samples were recognized based on the inclusion criteria and picked up with Non probability – purposive sampling technique. Beck's depression inventory was used as a tool for data collection after

confirming the validity and reliability. Reiki therapy was demonstrated to the experimental group only for 14 days in both morning and evening. The data obtained were analyzed and interpreted using descriptive and inferential statistics.

Results

- In control group 3(10%) had borderline level of depression, and 27 (90%) had moderate level of depression in pre-test, whereas the same samples 3 (10%) had borderline level of depression, 27(90%) had moderate level of depression in post-test.
- While seeing pre-test level of depression in experimental group 11(36.7%) had mild and19 (63.3%) had moderate level of depression. But in post- test 9 (30%) had borderline level of depression and 12 (40%) had mild level of depression and 9(30%) had moderate and no one had severe and extreme level of depression.
- In control group 27 (90%) had moderate level of depression, 3 (10%) had borderline level of depression in pre-test, whereas a similar finding was seen in post test. While seeing pre-test level of depression in experimental group 19 (63.3%) had moderate 11 (36.7%) had borderline level of depression. Whereas in post- test 12 (40%) had borderline level of depression and 9 (30%) had mild and moderate level of depression.
- The mean post-test score (23.33±4.52) was higher in control group than the mean post-test score (19.06±4.05)1 in experimental group among geriatrics. The mean difference in level of depression was 4.27. The obtained 't' value was 3.846 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing the level of depression in the experimental group and not in the control group.

- The mean pretest level of depression score (22.50±4.07) was lower than the posttest on the level of depression score (19.06±4.05) among geriatrics. The mean difference in level of depression was 3.44. Using the paired ‘t’ test, the obtained pre-test and post-test score of level of depression among geriatrics in experimental group revealed that ‘t’ value was 3.28 which showed a statistical significance at $p<0.001$ level.
- There was no association found between pretest level of depression with selected demographic variables in control and experimental group.

Conclusion

Reiki therapy is a non-pharmacological psychosocial intervention for the treatment of depression. The study results revealed that, there is significant difference on the level of depression among elderly in experimental and control group. The study concluded that Reiki therapy will decrease the level of depression and enhances comfort in elderly

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Introduction

CHAPTER I

INTRODUCTION

"Life isn't matter of milestones, but of moments"

BACKGROUND OF THE STUDY

The old age is an integral part of human life. It is the evening of life. It is unavoidable, undesirable, unwelcome and problem ridden phase of life. But it is really interesting to note that everybody likes to live a long life, but not to be old. It is ironical that however undesirable the old age that is bound to life. A man is compelled to go through the pains and pleasure of this age as like other phases in life, before making exit from this mortal world.

Though it is true that no stage of life has its ever smooth sailing and every stage has its attendant problems, those of old age are more difficult because the physical strength and mental capability required to cope up with the adverse situations of life are immensely reduced. The situation becomes all the more difficult when one finds himself/herself left alone without anyone to attend him.

Indeed the loneliness and neglect associated with the old age is a rather recent phenomenon. It is the outcome of breakup of the tradition of joint family system. Growing urbanization and fast moving modern life have contributed to the problem. Furthermore, the erosion of moral values has also aggravated the situation. Earlier, when life was simpler and values counted for more, those who reached a ripe old age held an enviable place in society where they could really release and enjoy the twilight years of life.

They commanded great respect, regard, love and attention and were taken as source of inspiration, guidance and experience for the younger generation.

These words of Elbert Hubbard are true to the situation, “where parents do too much for their children, the children will do not much for themselves.”

Debilitating body and failing health, make things worse. Having rendered service for a lifetime, the body parts appear to have become tired and weak. He becomes highly vulnerable to ailments-minor or major. Diseases both minor and major always follow them and their waking hours are preoccupied with symptoms and pills, diets and therapies. Regular medical aid and assistance becomes routine at this stage of life.

Besides, social security and emotional support are terribly needed. A feeling of loneliness adversely affects their mental health which shows through some physical problems. In recent times, insecurity of the old, particularly in metropolitan cities, has emerged as a matter of grave concern. Usually, they are alone with servants to take care of them. After some time, the servants become familiar with everything in the household, they rob them of all their belongings, often become cruel enough to kill them and ran away. The news of such incidents are frequent in national dailies.

The problem of loneliness and isolation is the gift of modern society. The society forces an old person to live like an island. Often he faces the loss of spouse and old friends. In fact, during the old age one is faced with multi-dimensional problems. One of the major problems is the financial constraint which is really more difficult in case of those old persons who are not entitled to any social security and have no source of income, completely depending on their spouse or children. People of this consumer culture do not have sufficient money to provide financial support to

their parents; neither do they take it as their moral responsibility. This situation is really unfortunate and needs to be addressed properly.

Added to this is the depressing anxiety of not knowing just how far ahead one must plan or for how long one is forced to dependent financially on his children to meet his requirements. This brings more despondency to him. This plays havoc with the lives of the person. The picture is really grim in the twilight years of the life which ought to have been the best years of a person's life, when man is free from every kind of responsibilities.

In fact, it is an appropriate time for him to enjoy life without care and concern. He finally has time to live-"sit in shade/reliving the good old times/letting bad memories fade." Keeping in mind these words of Henry Ward Beecher, "There is no friendship, no love, like that of the parent for the child," we should be sincere and caring enough to take care of them when they most need it, but not pamper them.

Depression is the most common diagnosis in older adults ,who have attempted suicide and suicidal rate due to depression among persons older than age of 65 is doubled compared with suicide rates of persons younger than 65.

According to the National institute of mental health (NIMH), 2010 major depression is a significant predictor of suicide in the geriatrics. The (age 65 and older) accounts for over 18% of all suicides, frequently depression goes unrecognized and there for untreated in the older population.

It is difficult to imagine how families who bear the burden manage to meet the needs of their depressed and suicidal loved one at home. Because the family members become the primary care givers, strategies to promote optimal family functioning would result in better care for the patient, there by entrancing patient outcomes.

Depression is not only a state of being sad, it is a disease that conquers the ability to feel emotion, whether good or bad, whatsoever. Depression not only involves the mind, it also involves the body and thoughts. In different cultures some complain of excessive headaches and extreme pain and this is identified as depression, moderate or otherwise. This disease can be passed down through genes or can follow external events or can be caused by a chemical imbalance in the brain

Reiki may help restore a person's overall sense of balance, both in the mind and the body. This may help to improve the person's mood and help him or her to overcome feelings of guilt and/or sadness.. However there are inherent difficulties in assuming from these studies that Reiki therapy for depression is an effective treatment with the general adult population..

Traditionally, the family has been the primary source of care and material support for the older adults throughout Asia. And, the Indian family system is often held at high position for its qualities like support, strength, duty, love, and care of the elderly. The responsibility of the children for their parents′ wellbeing is not only recognized morally and socially in the country, but it is a part of the legal code in many states in India. But urbanization, modernization, industrialization, and globalization have brought major transformations in the family in the form of structural and functional changes. As a result of these socio demographic changes, older adults at times are forced to shift from their own place to some institutions/old age homes.

However there are inherent difficulties in assuming from these studies that Reiki therapy for depression is an effective treatment with the general adult population

NEED FOR THE STUDY

An old man is full of experience are an immense help to the younger generation, he is taken as an unwanted burden. Thinking of old age visions terrible loneliness and neglect emerge in mind. A sense of despair glooms over all his pleasant feelings.

- Globally 10% to 30% of has the problem of depression and in India 13% - 15% of old age are affected with depression.
- In Tamilnadu 47% to 49.5% of depression and in Madurai 25% to 27% of old age are affected with depression.

During the researcher's visit to old age home, all the patients expressed their feelings of isolation from their family and felt their depressive state. To eliminate their feelings of depression, the researcher decided to do his research work for the wellness of clients.

The researcher viewed that depression will lead a person's life to a catastrophic state and lack of peace and also it has to be reduced by means of alternative therapy So the researcher has chosen Reiki therapy to eliminate the depression.

STATEMENT OF PROBLEM

A study to evaluate the effectiveness of Reiki therapy on depression among geriatrics in selected oldage homes at Madurai.

OBJECTIVES

- To assess the pretest & post -test level of depression among geriatrics in control group and experimental group.

- To assess the effectiveness of Reiki therapy on depression among geriatrics by comparing post test scores between control and experimental group.
- To compare the pretest and post- test level of level of depression among geriatrics in experimental and control group.
- To find out the association between the pretest scores of depression with selected demographic variables among geriatrics of control group.

Research Hypothesis

H_1 - The mean post-test scores of control group in significantly higher than the mean post test scores of experimental group.

H_2- The mean pre-test scores group is significantly higher than

the mean post-test depression score of experimental group

H_3-There is a statistically significant association between pre-test depression

score with selected demographic variables in control group.

Operational Definitions

Effectiveness of Reiki therapy

In this study, it refers to the significant reduction in the level of depression as determined by the differences between pretest and post- test depression scores.

Depression

In this study, it refers to a mood disturbances characterized by altered feelings, attitudes and belief felt by the geriatric people which is measured by Beck's depression inventory.

Geriatrics

In this study, it refers to senior citizens who are admitted in the selected old age home between the age group of 60-80 years.

Old age home

In this study, it refers to institution, providing professional care where old people can live together and be cared for when they are too weak or ill to take care of themselves by paying money.

Assumption

- Level of depression may vary from individual to individual.
- Reiki therapy may be effective in reducing the level of depression among geriatric residents.

Delimitations

- The setting of the study is limited to the geriatric residents of selected old age homes in Madurai.
- The sample size is limited to 60 subjects.
- The study period is limited to 4 weeks

Projected Outcome

- The study will help to identify the level of depression among geriatric residents at old age homes.
- Reiki therapy will reduce depression among. geriatric residents
- The findings of the study will help the nurses to practice Reiki therapy along with routine care in hospitals and homes.
- The findings of the study will help the health professional to gain knowledge for further research.

Review of Literature

CHAPTER- II

REVIEW OF LITERATURE

Researchers never conduct a study in an intellectual vacuum; their studies are actually undertaken within the context of an existing knowledge base. Review of literature is an important step in the development of a research project. The review of literature is defined as a broad, comprehensive in depth, systematic and critical review of scholarly publications, unpublished scholarly printed materials, audio visual materials and personal communications. **(Basavanthappa, B.T 2007).**

Review of literature of the present study was arranged in the following headings:

1. General Information about Reiki.
2. Literature related to depression in geriatrics.
3. Literature related to elderly in old age home.
4. Literature related to effectiveness of Reiki.

GENERAL INFORMATION ABOUT REIKI

Reiki therapy for human being is a wonderful and therapeutic gift in this era of continuous stress, tension and sickness. Massage is an art of Reiki with bare hands. It is considered as an important therapy in Indian system of Medicine for pain, muscle pull and some of the orthopedic conditions and especially in palliative care.

Considering the importance of Reiki in Nursing and incorporating cheap and acceptable complementary therapies is essential for broadening the scope of nursing. Aim: To assess the effectiveness of slow stroke back massage on quality of sleep among patients admitted in ICU. Material and Methods: A study was conducted using non-equivalent pre-test post-test control group design in the year 2011 -12. 60 samples, between age group of 25 to70 years were selected and divided into two

groups, control group and experimental group. The quality of sleep of all the samples was assessed by Modified Groninger's sleep quality assessment scale and recorded with check list. After routine night nursing care, the intervention was done for 10 to 12 minutes on experimental group and the control group was not given massage. This was done for three consecutive nights and every morning quality of sleep of all the samples was assessed and recorded. Findings: The majority of the samples were exposure to massage therapy. How ever due to sickness and environment in ICU they were not able enjoy quality sleep. The massage therapy was helpful in inducing sleep and improving the quality of sleep. There were significant differences on the quality of sleep before and after slow stroke back massage. This shows that there was gradual improvement in the sleep quality after back massage on 3 consecutive days. The back massage has effect on quality of sleep among ICU patients.

II. Literature related to Depression in Geriatrics

Jose John (2010) conducted a study to determine the effectiveness of pet therapy on depression among old age people residing in selected old age homes, Coimbatore. An evaluative research approach and quasi experimental, nonequivalent pretest-posttest control group design was used in the study and purposive sampling technique was used to select 60 samples. Modified geriatric depression inventory was used to assess the level of depression. The findings of the study suggested that majority of the old age persons had moderate depression and the study concluded that pet therapy was highly effective in reducing depression among old age persons.

Deborah Mitchell (2009) conducted a study on depressive symptoms and treatment. Structured psychiatric interview identifies depressive symptoms in 130 consecutively admitted male inpatients aged 70 +. Major depression was found in 11.5% and other depressive syndromes in 23%, socio demographic and health

characteristics of older men at higher risk for depression were also identified. Patients 27were over age 75 years, had less formal education, experienced cognitive dysfunction, suffered from more severe medical illness (particularly recent myocardial infarction), and had a history of psychiatric illness were at a risk of depression.

Yuki Mukai M.D, and Rajesh, R., Tampi MD, MS (2009) conducted a study comparing the efficacy of various antidepressant classes in elderly population in New zealand. The data from more studies using various measures (including changes in-Asberg Depression Rating Scale, HAM-D, or Geriatric Depression [GDS] scores; response rates; and remission rates) suggested no additional efficacy benefit for the SNRI venlafaxine compared with SSRIs or TCAs. In a single trial, duloxetine was significantly more effective than placebo in terms of reduction in HAM-D and GDS scores. The available data, although limited, suggest that the dual-action agents (TCAs and SNRIs) do not appear to confer any additional benefits in efficacy over single-action agents (SSRIs) in the treatment of depression in the elderly.

AT Beekman, JR Copeland and MJ Prince (2008) conducted a study to assess the prevalence of late-life depression in the community at Denmark. They reported that prevalence rates vary enormously (0.4-35%), arranged according to level of caseness, major depression is relatively rare among the elderly (weighted average prevalence1.8%), minor depression is more common (weighted average prevalence 9.8%), while all depressive syndromes were clinically relevant, yield an average prevalence of13.5%. There was consistent evidence for higher prevalence rates of depression for women and among older people living under adverse socio-economic circumstances.

Ather M Taqui (2007) conducted a study on depression in the elderly. He conducted the cross sectional study in a tertiary care hospital, Karachi, to determine the relationship between the type of family system and depression. He also28determined the prevalence of depression in the elderly, as well as, correlation of depression with other important socio-demographic variables. Questionnaire (Geriatric Depression Scale) based interviews schedule were conducted among the elderly people those who visiting the hospital. 400 subjects aged 65 and above were interviewed. 78% of them were male. The prevalence rate of depression among them was found to be 19.8%. Multiple logistic regression analysis revealed that the following were significant ($p < 0.05$) independent predictors of depression mainly nuclear family, female sex, being single or divorced/widowed, unemployment and\illiterate. The elderly living in a nuclear family were 4.3 times vulnerable to suffer from depression than in a joint family. The present study found that residing in anuclear family system is a strong independent predictor of depression in the elderly.

Jane McCusker. et.al., (2007) conducted study on major depression among medically ill elders contributes to sustained poor mental health in their informal caregivers. The longitudinal observational study with 6-month follow up conducted in two Montreal acute-care hospitals. A sample of 97 cognitively intact medical inpatients aged 65 + and their informal caregivers, with sampling of patients with a diagnosis of major or minor depression. Results of the analyses showed that in comparison with caregivers of patients without a present diagnosis of depression, caregivers of those with major depression had a lower mental health score at follow up, even though their physical health was slightly better.

Chaosy, Liuhy, (2006) conducted a quasi –experimental study on the effectiveness of group therapy in nursing. Home random sampling was used to recruit

participants. Residence of one ward was assigned to the reminiscence therapy group intervention while the residents of the other ward served as controls. One-hour sessions were designed to elicit reminiscence group therapy for 12 elders in the29experimental group and remaining in control group. Depression, self-esteem and life –satisfaction were measured one week before and after therapy. Result showed that there was significant reduction in depression and improvement in self-esteem.

Charles F. Reynolds, et. al., (2006) conducted a study on maintenance treatment of major depression in old age. Among patients with a response to treatment with paroxetine and psychotherapy, randomly 116 assigned to one of four maintenance-treatment programs for two years or until the recurrence of major depression. The result was the major depression recurred within two years in 35percent of the patients receiving paroxetine and psychotherapy, 37 percent of those receiving paroxetine and clinical management sessions, 68 percent of those receiving placebo and psychotherapy, and 58 percent of those receiving placebo and clinical management sessions (P=0.02). This study concluded that the patients 70 years of ageor older with major depression who had a response to initial treatment with paroxetine and psychotherapy were less likely to have recurrent depression if they received two years of maintenance therapy with paroxetine & monthly maintenance psychotherapy did not prevent recurrent depression.

Kathleen fisher. et. al., (2004) conducted a study on assessment of depression and cognitive impairment among elders in rural housing facilities. Psychiatric disorders are estimated to be 50% higher among older public housing residents than among the general elderly population. The purpose of the study was to assess for depression and cognitive impairment among rural elders in public housing. The study concluded that, depression and cognitive impairment can often herald

nursing home placements and nurses need to assess this at-risk population. The study also suggested that nursing case management including assessment, referrals, identification of 30 community services, patient and family education are critical to address these under recognized disorders.

Jongenelis. K et. al., (2004) conducted a cross sectional study on prevalence and risk indicators of depression in elderly nursing home patients. The prevalence and risk indicators of depression were assessed in 333 nursing home patients living on somatic wards of 14 nursing homes in the north west of the Netherlands. The result was the prevalence of major depression was assessed to be 8.1% and the prevalence of minor depression was 14.1%, while further 24% of the patients suffered from subclinical depression. This study concluded that the prevalence of depression in the nursing home population is very high. Age, pain, visual impairment, stroke, functional limitations, negative life events, loneliness, lack of social support and perceived inadequacy of care were found to be risk for depression.

Sokoya (2003) conducted a descriptive study to determine the rate of geriatric depression among 202 older people in a teaching hospital in Nigeria, by using geriatric depression scale. The rate of geriatric depression in primary care was found to be 7.4% and severe depression was only 1.5%. Very low income and subject report of poor health was significantly associated with depression.

Richson. NE (2003) conducted study to determine the prevalence rate of Depression. The Study sampled 8449 people between the age group of 15 and 40 years. The study design controlled for age, gender, educational level and marital status, allowing researchers to pinpoint differences that could be accounted to by race/ ethnicity. Based on their responses to the DSM-IIITR Questionnaire. Depressed subjects were characterized as Major Depressive Disorder[MDD],Chronic Dysphonic

Mood [CDM] Dysthmic Disorder [DD]. Though prevalence of MDD significantly greater in White individuals compared with African Americans [10.4%,7.5%] DD[7.5%,5.7%] & CDM [13.5%,7.6%] than White participants .Recurrent Depression was more common in White participants [18.2%]than in African American participants [13.3%]. The study was concluded that the Depression is an major life threatening disease seen in the population.

Vitale.E(2003)a study conducted among 627 elderly individuals of 60 years and above in the rural area of Udupi Taluk. The objectives was to determine the prevalence of Depression and to study correlates of Depression. Among elderly. In this study, the prevalence of Depression among elderly population was determined to be21.7%. The prevalence in the age group of 80 years and above and those individuals who had a history of death in the family with in the sixth months were found to be 34.4% and 52.4% respectively. The study concluded that these two correlates were indecently associated with Depressive disorders in elderly population

III. Literature related to Geiatrics in Old Age Home

Nilsson, (2007) conducted a cross sectional study in rural Bangladesh and Vietnam to assess the health, quality of life in elderly in old age homes and found that there were similarities between the two countries. Advanced age, being a woman, belonging to poor households and having a poor self reported health status were significantly associated with poor health related quality of life. Illiteracy was additionally found to be a significant determinant of poor health related quality of life in Bangladesh.31

Kenmare, (2000), conducted a study on recognizing and managing depression in women for 40 samples in old age home. The study revealed that

depression is 50% common in women as in men, and women often experience different symptoms, a different course and a different response to treatment as old age may cause or exacerbate depression.

Kavitha A.K., (2000) did a comparative study on the quality of life among senior citizens living in home for the aged and senior citizens in the family set up. The sample size was 100 and the research approach was comparative survey. The modified WHO standardized tools were used by the investigator. The above mentioned study found that the over all mean score regarding quality of life was found higher among the senior citizens living in family set up than the senior citizen living in old age homes.

Rajan, (2000) conducted a descriptive study in Kerala to know the reasons why the elderly approach old age homes. The results were, no one to take care of them (67%), children away from the family (1%), problems with children (8%) and own preference (24%). He also said that 82% of inmates reported that the quality of life in old age home was alright and only 1% of the elderly said that environment in old age home is bad and 16% said that they liked the environment very much.

IV. Literature related to Effectiveness of Reiki therapy.

Kaur.G(2011)conducted a study to assess for Long term effects of Reiki therapy on Depression.45 participants with symptoms of Depression volunteered for this study. Participants were randomly assigned to one of three groups; Hands on (Reiki)Reiki, Distance (non Reiki) Reiki, and Distance Reiki placebo. The study suggested that Reiki therapy have an significant reduction in Depression. participants were not received aware of which group would be receiving placebo Reiki.12 Reiki masters, and three second degree Reiki practioners were chosen to conduct the one to

one and one- half hour sessions. Each participants received one treatment weekly for 6 weeks. Three tests designed to measure levels of Depression, were administered each participants before and after the series of 6 sessions.1 year later, the participants retook the three tests. After testing was completed, the control placebo group received another 6 weeks of Reiki treatments, this time with actual Reiki, and three test were administered to this group again findings of the study demonstrated that there were no changes in the control\ placebo group until they received 6 session of actual Reiki a year after the first 6 placebo sessions. Both the hands on and the distance Reiki were effective in relieving symptoms of Depression. The study concluded that Reiki therapy have an long term effects in reduction of Depression.

Iran J Nurs Midwifery Res. 2010 Winter; .conducted a study to assess the impact of therapeutic Reiki on medical vital signs of patients before coronary artery bypass graft surgery. The present study is a clinical trial with 44 samples that were selected by easy sampling method and based on two separate lists of random numbers for both men and women; they were divided into two groups. In the therapeutic Reiki group, intervention therapy was applied on patents for 20 minutes. Data was analyzed using descriptive and inferential statistics. Test results showed that there was a significant difference between the mean pulse rate before and after intervention in both groups ($p < 0.001$). Results also showed that there was a significant difference between the average number of breathing before and after intervention in both groups ($p < 0.001$). Considering the effects of therapeutic Reiki therapy as a safe and effective intervention on the patients which were revealed in this study, this technique can be used as a simple, cheap and applicable technique in all health care centers to help these patients

Shrimathi.C (2010) conducted a study to evaluate the effect of Reiki in Depression patients. 20 participants were randomly assigned to either an experimental or wait list control group. The pre and posttest measures by Beck Depression Inventory Scale. The research design included an experimental component to examine changes in these measures and a descriptive component [semi structured interview] to elicit information about the experience of having Reiki treatment. There was76% reduction occur in experimental group and 24% have no changes. The study concluded that a significant differences were observed between the experimental and control groups on measurement.

Sudheesh P.S (2009)conducted a study to assess the effectiveness of Reiki therapy in Depression. The research design used in this study was pretest\ posttest treatment and wait list control design.76 self selected participants from general population were selected. They were randomly divided in to two groups. one was received Reiki therapy another group was not received. Zung Self – Rating Depression scale was used for measuring Depression.82% of patients were reduced Depression and 18% of patients are still like that. The study concluded that Reiki therapy effective for treating Depression.

Zeynep Erdogan & Sezgi Cinar (2006) conducted a study to evaluate the effect of Reiki on depression in elderly persons living in nursing homes. The study was conducted randomized, controlled and experimental. The study universe consisted of 170 elderly and due to the long duration of the study and 90 elderly who volunteered for the study and fulfilled the inclusion criteria formed the sample. Ninety elderly individuals who were included in the study were separated into 3 groups using the random sampling method: 30 in the reiki group, 30 in the sham reiki group, and 30 in the control group. Data was collected using the Geriatric Depression

Scale (GDS). There was a significant decrease in depression score of the Reiki group while there was no significant difference in depression scores of the sham Reiki and control group on the 4th, 8th and 12th weeks considering 1st week. In addition, the depression score of the Reiki group was lower than the depression scores of the sham Reiki and control group on the 4th, 8th and 12th weeks. The results of this study indicate that Reiki might be effective for reducing depression in elderly persons living in nursing homes.

Melanie AshfeldSt. Catherine University (2006) There approximately 5.1 million Americans who may have Alzheimer's disease (AD). This number is expected to increase with the increase in the aging population. Theories based on genetic and neuropath logical findings suggest genetic mutations are responsible for AD. There are 7 stages of AD. The stages of disease are a reference on how the disease may progress, but not all stages are experienced by all persons with AD. AD can only be diagnosed by histopathology examination of the brain there for clinical criteria are utilized for diagnosis. Clinical criteria include diagnostic tests such as laboratory and imaging studies, neuropsychological testing, mental status exam, and neurologic exam. The majority of persons with AD exhibit behavioral symptoms. Behavioral symptoms may include disruptive vocalization (screaming), restlessness, repetitive questions, wandering, pacing, and physical aggression toward self or others. Treatment of behavioral symptoms is challenging and a wide range of interventions are utilized by caregivers and health care professionals. Chemical and physical restraint utilization for behavioral symptoms can lead to a higher risk for falls. Family caregivers of AD patients have a high incidence of depression as consequence of caring for a person with dementia. Therapeutic Reiki is a non-pharmacologic intervention that has been minimally utilized for the treatment of behaviors seen in

patients with AD. It has been found through research to decrease stress and anxiety, and to improve quality of life and emotional, physical, and spiritual well-being. Evidence has shown therapeutic Reiki does not cause patients any harm. An intensive review of the literature and studies on the use of therapeutic Reiki as an intervention to treat behavioral symptoms of AD indicates that it is appropriate for primary care givers to consider therapeutic Reiki therapy to treat behaviors of patients with AD.

John Westfield(2005) conducted a study to find out the effectiveness of body-oriented and somatic psychotherapies, both in international and Australian settings. A systematic review of internationally published research from the last five years and Australian research from the last 10 years was conducted using the Cochrane Library, Google Scholar, Medline, PsycINFO and PubMed. Overall 19 effectiveness studies and 38 reviews met the inclusion criteria. Body-oriented psychotherapy interventions have been found to be effective in different populations and settings. However, in comparison with more established therapeutic modalities, body-oriented psychotherapy interventions require further empirical research to be deemed effective according to the American Psychiatric Association (APA) standards.

Carolyn Magdalene Monroe(2005) conducted a study to understand how Therapeutic Reiki can be used in today's health care arena, this integrative literature review will examine current research that will help answer the question, Does Therapeutic Reiki reduce pain? An extensive search was conducted of the online databases MEDLINE, CINAHL, Cochrane Library, EMBASE, PsychLIT, and PubMed to retrieve research articles published from 1997 to 2007. Seven studies that were conducted between 1997 and 2004 were found and only five of the seven were included as pertinent evidence to answer the question. All of the research that was

reviewed to answer whether Therapeutic Reiki could significantly reduce pain revealed a majority of statistically significant positive results for implementing this intervention. Because there are no identified risks to Therapeutic Reiki as a pain relief measure, it is safe to recommend despite the limitations of current research. Therapeutic Reiki should be considered among the many possible nursing interventions for the treatment of pain.

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CONCEPTUAL FRAMEWORK

The concept is a thought, idea, or mental image framed in mind response to learning something new. A frame work is a basic structure supporting anything.

In this study the researcher adopted “Modified J.W Kenny’s open system model” (1990) as a basis for conceptual framework. According to J.W. Kenny all living systems are open and there in continuous exchange of matter, energy, and information, various degree of interaction, with the environment from which the system receives input and gives back output in the form of matter, energy of information. System model consist of 3 phases (i.e) input, throughput, output.

INPUT

A system imports products in a process known as input.

In this study the input refers to assessment of the demographic variables such as age, gender, religion, educational status, material status, and source of income, number of children, duration, of stay in old age home, any medical illness, and history and of taking medications and the level of depression was assessed by using Beck’s depression inventory from both experimental and control group.

THROUGHPUT

A system transforms, creates and organizes the process known as throughput, which results in a registration of the orientation. The matter of energy and information continually processed through the system, known us throughput. Process is the use of input energy and information for the maintenance of homeostasis of the system.

In the present study, process includes the administering Reiki therapy to the experimental group and no intervention to the control group.

OUTPUT

A system exports products in a process known as output. The output is the reduction in the level of depression for geriatrics. J.W. Kenny noted after processing the input, system return to output (matter energy, information) to the environment. Change is a feature of a process that is observable and return as output which should different from that which is entered in the system. In the present study, output is the difference in the level of depression between post test scores of control group and experimental group.

FEEDBACK

If there is any inadequacy in output, the feedback emphasis to strengthen the input and throughput. In this study, feedback is essential for the individuals having severe depression.

According to theorist, information of environmental responses to the system, output is utilized by the system in adjustment, correction & accommodations to the interaction with the environment.

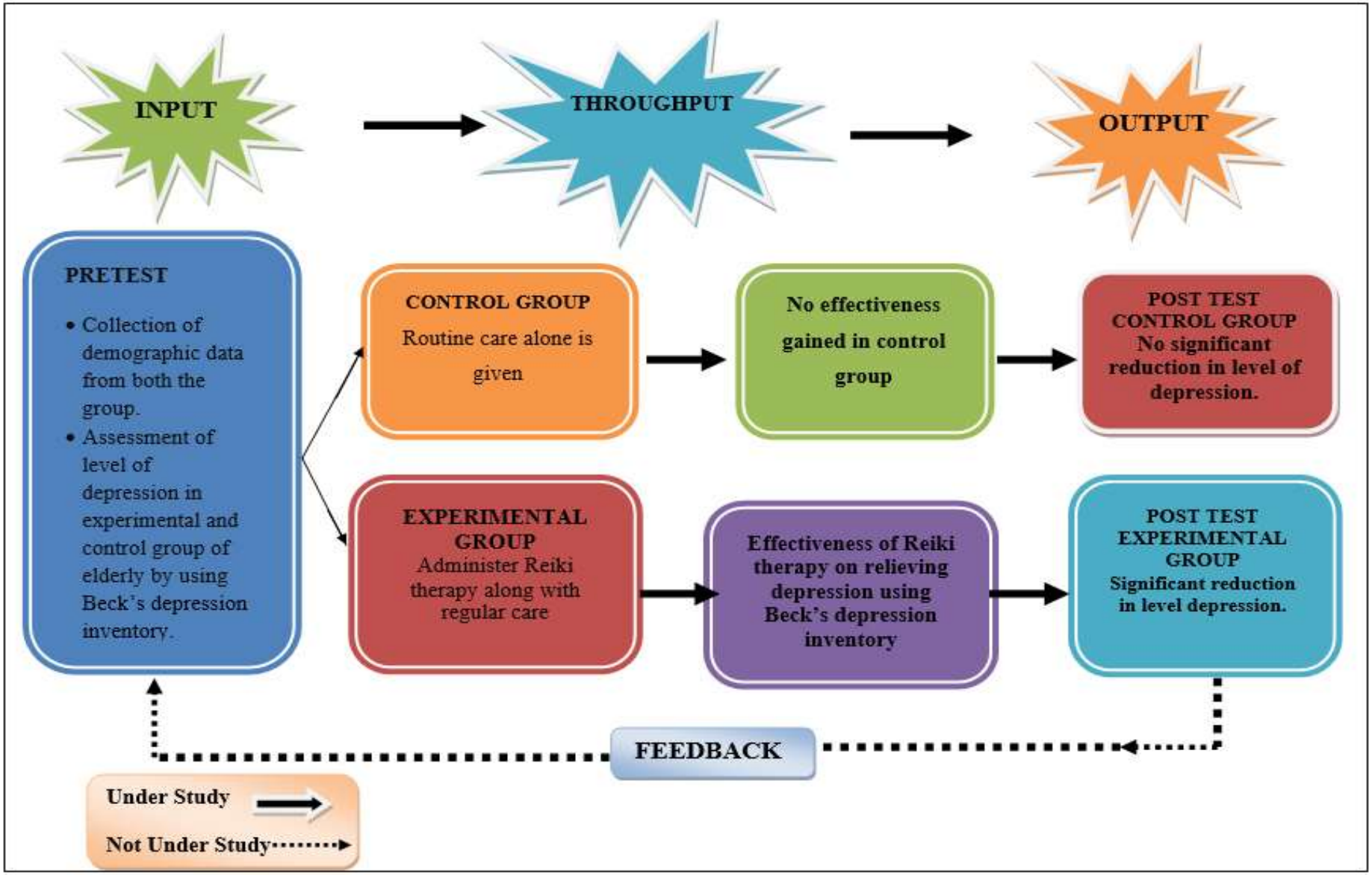
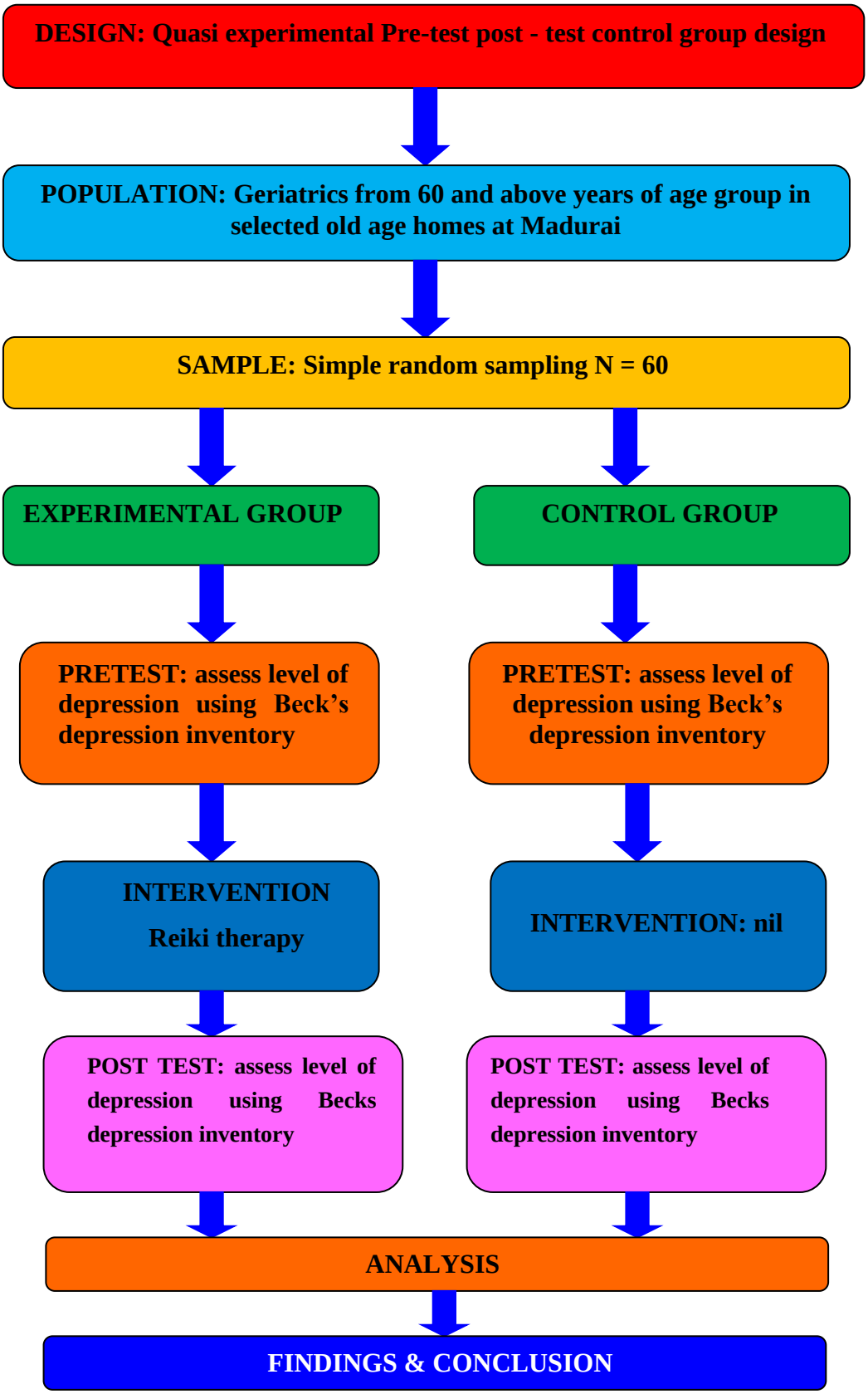


Fig 2.1: CONCEPTUAL FRAMEWORK BASED ON MODIFIED J.W. KENNY'S OPEN SYSTEM MODEL (1990)

Methodology

CHAPTER – III

Figure 3.1 SCHEMATIC PRESENTATION OF RESEARCH



METHODOLOGY

The methodology of research refers to the principle and idea on which researcher base their procedure and strategies. **(Immy and Wheeler, 2002)** The present study is carried out to determine the effectiveness of Reiki therapy on level of depression among the geriatrics of old age home with the view of preventing psychological problems and physical problems and to promote excellent nursing care.

Research Approach

The objective of the present study was focused to evaluate the effectiveness of Reiki therapy on the level of depression among geriatrics. The researcher used a quantitative approach to evaluate the objectives.

Research Design

The research design chosen for this study was quasi experimental pre-test post- test control group design was used.

GROUP	PRE-TEST	INTERVENTION	POST-TEST
CONTROL GROUP	O1	-	O2
EXPERIMENTAL GROUP	O1	X	O2

E : Experimental Group

C : Control Group

O1 : Pre-test

X : Intervention (Reiki therapy)

O2 : Post-test

-:No intervention

Variables

In the present study, Depression is the dependent variable.

In this study Independent variable is Reiki Therapy.

Description of the Setting

The study was conducted in selected Old age homes namely Christian Seva Trust Old age Home, Alagappan nagar and C.S.I Christian Mission old age home Madurai, which are run by a private organization. Christian Seva Trust Old age home has a total of 48 residents which is situated 4 kms away from the our college. C.S.I Christian mission Old age home has a total of 58 residents which is situated 8 kms away from our college.

Population

The target population was all the geriatrics at geriatrics homes in Madurai.

The accessible population were all geriatrics in selected institution Christian Seva Trust and Christian Mission Hospital in Madurai.

Sampling

Sample

The sample of this study was geriatrics people those who residing in Christian Seva Trust, &C.S.I Christian Mission Old age home, Madurai.

Sample size

The sample size was 60. Among them, 30 samples were allotted for experimental group and 30 samples were in the control group.

Sampling technique

The sampling technique adopted for this study was simple random sampling technique by using lottery method.

Criteria for sample selection

Inclusion criteria

- Those who co--operate during the study.
- Elders who are age group between 60-80 years.
- Those who understand and speak Tamil.
- Both male and female residents.

Exclusion criteria

- Those who are seriously ill during the data collection period.
- Residents who are previously exposed to the Reiki therapy.
- Residents with severe and extreme depression and major illness

Description of the Tool

The instrument consist of was used to assess the level of depression in geriatrics residents (structured interview schedule). It consists of 2 sections.

Section I: Demographic data of the samples

Section II: Structured questionnaire to assess the level of depression using the Structured Interview schedule (Beck's Depression inventory)

Section-I

This section deals with the demographic data in relation to age, sex, Marital status, source of income, religion, previous occupation, educational status, previous type of family, number of children, medical illness, reason for joining at old age home and duration of stay in old age home.

Section-II

It deals with a structured questionnaire which is used to assess the level of depression among the geriatrics residents Beck's Depression Inventory used. This scale consists of 21 questions multiple choice self-report inventory, one of the most widely used psychometric test for measuring the severity of depression components (Psychological problems, Physical problems).

SCORING PROCEDURE

The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question.

Obtained Score is interpreted as follows

LEVEL OF DEPRESSION SCORES

- 0-9: indicates minimal depression
- 10-18: indicates mild depression
- 19-29: indicates moderate depression
- 30-63: indicates severe depression

VALIDITY AND RELIABILITY OF THE TOOL

Validity

Validity of the tool was obtained on the basis of opinion of medical expert (in the field of psychiatry) and 4 nursing experts (In the field of mental health nursing). The tools were found adequate and were translated into Tamil.

Reliability

The reliability of the tool was assessed by test re-test method and score obtained was ‘r’=0.87 which shows that the tool was reliable.

PILOT STUDY

The researcher conducted the pilot study at Inba illam at Madurai. After obtaining administrative approval from the concerned authorities, the researcher selected 6 old age clients, after getting the consent from each person. Out of 6samples, each 3 samples were chosen for experimental and control group for study. Pre-test was carried out for both groups regarding level of depression by using self-administered questionnaire. On the same day after pretest, adult in the experimental group were given Reiki therapy. Post-test was carried out after 7 days by using the same self-administered four point rating scale for both groups. The study was found to be feasible with regards to time, the availability of subjects and the cooperation of the samples. It also provided information regarding reliability, feasibility and practicability of the designed methodology.

METHOD OF DATA COLLECTION

Ethical considerations

Written permission was obtained from the managing director of the selected old age homes. Informed oral consent was obtained from geriatrics residents who are willing to participate in this study.

DATA COLLECTION PROCEDURE

Data collection is the process of gathering information needed to address and search probe. The data were collected for 6 weeks in the month of January 2017. Prior permission from the authority was sought. A convenient time and date was fixed

for data collection. The study sample was selected by simple random sampling based on the sample selection criteria. A total of 60 geriatrics of Christian seva trust and Christian Mission hospital geriatric home, Madurai were selected for this study. The objectives and the purpose of the study were explained and confidentiality was maintained. Data were collected from the adult persons for a period of 6 weeks. The purpose of the study was explained to the authorities. The adult persons were approached by the investigator. An initial rapport was established with the adult. Details of the study are explained to them. Pre- test on level of stress was done among 60 geriatrics of Christian Seva Trust and Christian Mission hospital geriatric home at Madurai. The sample size includes 60 geriatrics. The investigator approached the concerned authorities of concerned person for a convenient date and time for conducting the study. Then Reiki therapy was administered followed by needed explanations. The duration of Reiki therapy is 5 hours per day for a period of 2weeks. The post test was administered to the same group with same self-administered four point rating scale after 14 days of planned program. All the geriatrics were very cooperative. The investigator expressed his gratitude to the in charge person, geriatrics and other authorities of Christian Seva Trust and Christian Mission hospital geriatric home at Madurai for their co-operation during the entire study.

SCHEDULE FOR DATA COLLECTION PROCEDURE

Group	Period	Setting	Task
Experimental	4Weeks	Christian Seva Trust	Day 1 • Step 1-Orientation • Step 2- Pre-test • Step 3- Implementation of intervention Day 8 • Step 4- Post -test
Control		Christian Mission hospital geriatric home	Day 1 • Step 1-Orientation • Step 2- Pre –test Day 8 • Step 3- Post- test

STEPS OF DATA COLLECTION PROCESS

Step I

- Self-introduction about the researcher to the Geriatrics.
- Explanation about the purpose of the study and oral consent obtained.
- Good rapport was maintained with the Geriatrics.
- Patients were made comfortable and privacy was provided.

Step II

- Selection of sample and allotment to experimental group and control group based on the inclusion criteria.

Step III

- Samples were oriented to Reiki therapy.

- Pre-test was done for both experimental and control groups.
- Educational programme on Reiki therapy was projected only to the patients in the experimental group.

Step IV

- Post-test was conducted for both the experimental and control groups using the same tool on the eighth day.
- After the data collection procedure, educational programme on Reiki therapy was given to the control group for ethical consideration.
- A hearty gratitude was conveyed for the patients for the patients for their co-operation and participation.

PLAN FOR DATA ANALYSIS

Data analysis helps the researcher to organize, summarize, evaluate, interpret and communicate the numerical facts. For the present study the collection data from the participants were grouped and analyzed using both descriptive and inferential statistical methods.

- Gather all responses obtained from the study tool
- Enter the scores in the spreadsheet
- Coding the data

Descriptive statistics

Demographic variables were analyzed using frequency distribution, mean and standard deviation.

Inferential statistics

- Pre and post –test of depression within the group was analyzed by using paired “t” test.
- Post –test levels of depression between the groups were analyzed using independent “t” test.
- Association between demographic variables and pre-test level of depression was analyzed using chi-square test.

ETHICAL CONSIDERATION

The basic responsibility of the investigator in carrying out the nursing research is to give protection to all the study participations from harm of any forms. Approval from the ethical committee members of C.S.I.Jeyaraj Annapackiam College of Nursing, Pasumalai, Madurai and concerned authorities were obtained. Each individual was informed about the purpose of the study and confidentiality was promised and ensured. The clients have the freedom to leave the study at their wish without assigning any reason. Based on the ethical consideration, intervention was also given to the control group at the data collection process. Thus ethics were ensured in the study.

Data Analysis and Interpretation

CHAPTER IV

DATA ANALYSIS AND INTERPTRETATION

This chapter deals with analysis and interpretation of the present study involves compilation, editing, coding, classification and presentation of the data for statistical calculation in order to draw inferences and conclusions, using descriptive and inferential statistic, the study objectives were computed. The data collected from the samples to evaluate the effectiveness of Reiki therapy on the level of depression among geriatrics were organized, analyzed, tabulated and interpreted.

ORGANIZATION OF STUDY FINDINGS

Section A: Data on description of demographic variables of geriatrics in experimental and control group.

Section B: Data on assessment of level of depression among geriatrics in experimental and control group.

Section C: Data on effectiveness of Reiki therapy on the level of depression among geriatrics in experimental and control group.

Section D: Data on association between the levels of depression with the selected demographic variables among geriatrics.

SECTION: A

Table: 4. A.1: Frequency and percentage wise distribution of geriatrics residents based on their socio-demographic variables.

(N=60)

Demographic variables	Control group (n=30)		Experimental group (n=30)	
	f	%	f	%
1.Age in years				
a) 60-65	6	20	6	20
b) 66-70	9	30	9	30
c) 71-75	10	33.33	10	33.33
d)76 – 80	5	16.67	5	16.67
2. Gender				
a) Male	18	60	12	40
b) Female	12	40	18	60
3.Religion:				
a) Hindu	8	26.67	1	36.67
b) Muslim	6	20	3	10
c) Christian	14	46.67	16	53.33
d) Others	2	6.67	0	0
4.Educational Status:				
a) illiterate	5	16.67	5	16.67
b) Primary education	9	30	8	30
c) Secondary Education	12	40	12	40
d) Higher Secondary	4	13.33	5	13.33
5.Marital Status :				
a) Married	13	43.33	11	36.7
b) Unmarried	5	16.67	5	16.67
c) Widow	10	33.33	12	40
d) Divorced	2	6.67	2	6.67

6.Source of Income :				
a)Pension	9	30	9	30
b) Government Aid	6	20	5	16.67
c) Property	12	40	12	40
d)Interest from Savings	3	10	4	13.13
e) Others	0	0	0	0
7.Number of Children:				
a) No Children	5	16.67	4	13.33
b) One	9	30	8	26.67
c) Two	10	33.33	11	36.67
d) More than Two	6	20	7	23.33
8.Duration Of Stay in Oldage Home:	4	13.33	5	16.67
a) Less than 12 months	10	33.33	13	43.33
b) 1-3 Years	16	53.33	12	40
c) More than 3 Years				
9.Any Medical illness :				
a) Diabetes Mellitus	6	20	6	20
b) Hypertension	9	30	9	30
c) Respiratory problem	10	33.33	10	33.33
d) Cataract	5	16.67	5	16.67
e) Nil	0	0	0	0
10. History of Taking medication for major illness				
a) Yes	25	83.33	25	83.33
b) No	5	16.67	5	16.67

Table 4.A.1

Shows the frequency & percentage distribution of demographic variables with respect to age, gender, religion, educational status, marital status, source of income, Number of children, duration of stay in old age, home, any medical illness and history of taking medication for major illness.

- Regarding age, among the geriatrics, majority 10 (33.3%) were in the age group of 71– 75 years of age in both control group and experimental group.
- Based on gender majority, 18(60%) of geriatrics were males, where as 18 (60%) in the experimental group were females.
- Based on religion majority, 14 (46.67%) were Christians in both the experimental group and control group.
- Based on educational status majority 12(40%) of them completed the secondary education in both control group and experimental group.
- Based on marital status majority 13(43.33%) gotmarried in control group and 12(40%) got married in experimental group.
- With regard to the source of income majority 12(40%) had their own property in both control group and experimental group .
- Regarding number of children, majority 10(33.33%) had two children in control group, and 11(36.67%) had two children in the experimental group.
- Based on the duration of stay in old age home 16(53.33%) were staying more than 3 years in control group and 13(43.33%) were staying in old age home for 1-3 years in the experimental group.
- With regard to medical illness 10(33.33%) were suffering from respiratory problems followed by other illness in both control group and experimental group.
- While seeing history of taking medication for major illness 25(83.33%) is taking medications in both control group and experimental group.

SECTION B

Table 4.B.1 Comparison on pre-test and post-test mean score level of depression among geriatrics in control and experimental group

(N=60)

Level of depression	Control group				Experimental group			
	Pre- test		Post- test		Pre- test		Post -test	
	f	%	f	%	f	%	f	%
Normal	-	-	-	-	-	-	-	-
Mild	-	-	-	-	-	-	9	30
Borderline	3	10	3	10	11	36.7	12	40
Moderate	27	90	27	90	19	63.3	9	30
Total	30	100	30	100	30	100	30	100

Table 4.B.1 reveals the comparison of pre-test and post-test mean score level of depression among geriatrics in control and experimental group.

In control group 3(10%) had borderline level of depression, and 27 (90%) had moderate level of depression in pre-test, whereas the same samples 3 (10%) had borderline level of depression, 27(90%) had moderate level of depression in post-test.

While seeing pre-test level of depression in experimental group 11(36.7%) had mild and19 (63.3%) had moderate level of depression . But in post- test 9 (30%) had borderline level of depression and 12 (40%) had mild level of depression and 9(30%) had moderate and no one had severe and extreme level of depression.

Hence it is inferred that the depression clients who underwent Reiki therapy and reduction in the level of depression from moderate and borderline to mild and borderline level of depression.

Figure 4.B.1 Comparison of pre-test and post-test level of depression scores among geriatrics in control and experimental group

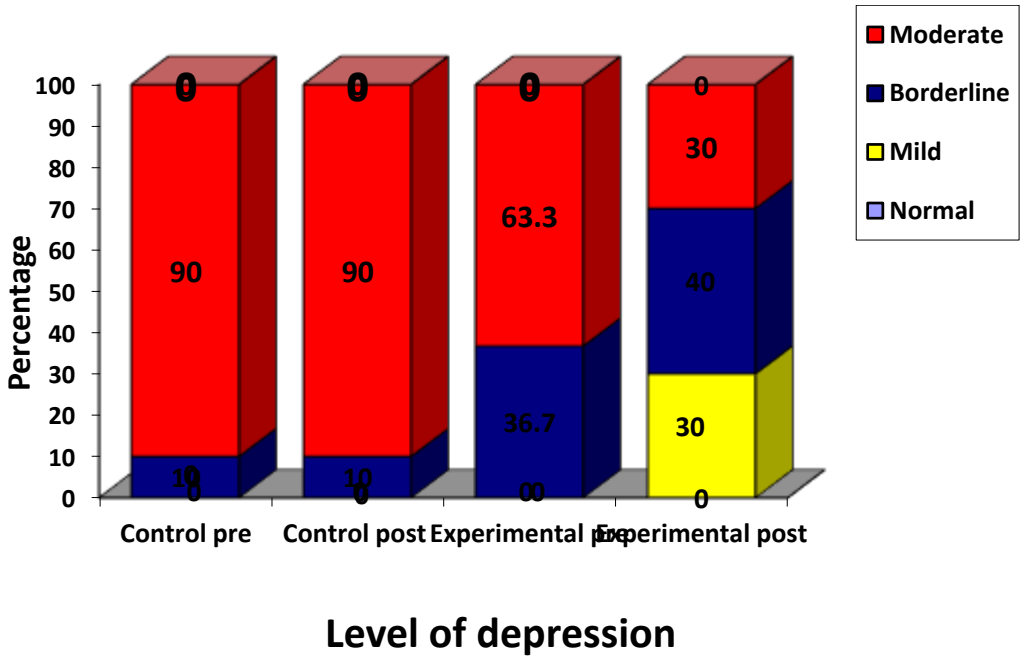


Figure 4B.1shows the comparison of pre-test and post-test level of depression scores among geriatrics in control and experimental group.

In control group ,27 (90%) had moderate level of depression, 3 (10%) had borderline level of depression in pre-test, whereas a similar finding was seen in post-test. While seeing pre-test level of depression in experimental group 19 (63.3%) had moderate 11 (36.7%) had borderline level of depression. Whereas in post- test 12 (40%) had borderline level of depression and 9 (30%) had mild and moderate level of depression.

Hence it is inferred that the depression clients who underwent Reiki therapy had reduction in the level of depression from moderate to borderline, mild and normal level of depression.

SECTION: C

TABLE-4.C.1. Mean score difference of pre-test and post-test on depression among Geriatrics in the control group.

(n=30)

Level of depression	Max score	Control-Pre test scores			Control- Post test scores			Difference in mean %
		Mean	SD	Mean %	Mean	SD	Mean %	
Overall	63	23.03	4.48	36.5	23.33	4.52	37	0.5

Table 4.C.1 shows the mean score difference of pre-test and post-test on level of depression among in the control group.

It reveals the overall mean percentage pre-test score is (23.03±4.48) and over all post -test score (23.33±4.52) and the overall mean difference is 0.5

TABLE 4.C.2. Mean score difference of pre-test and post-test on depression among geriatrics in the experimental group.

(n=30)

Level of depression	Max score	Experimental -Pre test scores			Experimental - Post test scores			Difference in mean %
		Mean	SD	Mean %	Mean	SD	Mean %	
Overall	63	22.50	4.07	35.7	19.06	4.05	30.1	5.6

Table4.C.2 shows the mean score difference in pre- test and post -test level of depression among geriatrics in experimental group.

It reveals that overall mean percentage pre-test score was (22.50±4.07)and overall post- test score (19.06±4.05) and the overall mean difference is 5.6 which was found to be statistically highly significant.

TABLE 4.C.3 Mean score difference on depression among geriatrics between the control and experimental groups.

(N=60)

Level of depression	Max score	Control post test scores			Experimental - Post test scores			Difference in mean %
		Mean	SD	Mean %	Mean	SD	Mean %	
Overall	63	23.33	4.52	37	19.06	4.05	30	7

Table 4.C.3 presents the comparison of the mean score difference between the control group and experimental group on level of depression in the post-test.

In the experimental group, post-test mean score is decreased (19.06±4.05) than the control group post-test mean score of (23.33±4.52) with the mean score difference of 7.

This result signifies that there is difference between the post-test mean score of depression in control group and experimental group, which means that the intervention on Reiki therapy is effective.

TABLE 4.C.4 Unpaired 't'test on posttest level of depression score among geriatrics between control and experimental group

(N=60)

Level of depression	Control post test		Experimental post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	23.33	4.52	19.06	4.05	4.27	3.846	P<0.001***

Table 4.C.4 shows the post test mean, SD, mean % mean difference and 't' value on the level of depression between experimental group control group.

The mean post-test score (23.33±4.52) was higher in control group than the mean post-test score (19.06±4.05)1 in experimental group among geriatrics. The mean difference in level of depression was 4.27. The obtained 't' value was 3.846 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing the level of depression in the experimental group and not in the control group. Hence the research hypothesis H2 is accepted.

TABLE 4.C.5 .Paired 't'test on depression score among geriatrics with the control group

(n=30)

Level of depression	Control pre test		Control post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	23.03	4.48	23.33	4.52	0.3	0.258	0.797

Table 4.C.5reveals that the paired 't' test score on depression within the control group is 0.258 and p=0.797 at p< 0.001 level. This indicates that this difference is not significant within the pre-test and post-test score.

TABLE 4.C.6 Paired 't'test on depression among geriatrics within the experimental group.

(n=30)

Level of Depression	Experimental pre test		Experimental post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	**22.50**	**4.07**	**19.06**	**4.05**	**3.44**	**3.28**	**0.001****

Table 4.C.6 shows the pre-test and post-test mean, SD, mean % mean difference and't' value on the level of depression in experimental group.

The mean pretest level of depression score (22.50±4.07) was lower than the mean posttest on the level of depression score (19.06±4.05) among geriatrics. The mean difference in level of depression was 3.44. Using the paired 't'test, the obtained pre-test and post-test score of level of depression among geriatrics in experimental group revealed that 't' value was 3.28 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing depression level among geriatrics. Hence the research hypothesis H3 is accepted.

TABLE 4.D.1 Association between pre-test level of depression among geriatrics with their selected demographic variables in the control group.

(n=30)

Demographic variables	Borderline		Moderate		χ^2	p-value
	f	%	f	%		
1.Age in years						
a) 60-65	1	3.33	5	16.7		
b) 67-70	1	3.33	8	26.7	2.784	0.426
c) 71-75	4	13.3	6	20	(df=3)	NS
d)76 - 80	2	6.7	3	10		
2. Gender						
a) Male	5	16.7	13	43.3	0.028	0.866
b) Female	3	10	9	3	(df=1)	NS
3.Religion:						
a) Hindu	3	10	5	16.7		
b) Christian	1	3.3	5	16.7	1.540	0.673
c) Muslim	3	10	11	36.3	(df=3)	NS
d) Others	1	3.3	1	3.3		
4.Education Status:						
a) Illiterate	1	3.3	4	13.3		
b) Primary Education	3	10	6	20	0.341	0.952
c) Secondary Education	1	10	9	30	(df=3)	NS
d) Higher Secondary	3.3	3.3	3	10		
5.Marital Status :						
a) Married	1	3.3	12	40	4.314	0.230
b) Unmarried	2	6.7	3	10	(df=4)	NS
c) Widow	4	13.3	6	20		
d) Divorced	1	3.3	1	3.3		
6.Source of Income :						
a)Pension	3	10	6	10	1.875	0.599
b) Government Aid	1	3.3	5	5	(df=3)	NS

c) Property	4	13.3	8	8		
d)Interest from Savings	0	0	3	3		
e) Others						
7.Number of Children:						
a) No Children	2	6.7	3	10		
b) One	1	3.3	8	26.7	1.761	0.623
c) Two	3	10	7	23.3	(df=3)	NS
d) More than Two	2	6.7	4	13.3		
8.Duration Of Stay in Old Age Home:						
a) Less than 12 months	0	0	4	13.3	2.642	0.267
b) 1-3 Years	2	6.7	8	26.7	(df=2)	NS
c) More than 3 Years	6	20	10	33.3		
9.Any Medical illness :						
a) Diabetesmellitus	2	6.7	4	13.3	0.682	0.877
b) Hypertension	3	10	6	20	(df=3)	NS
c) Respiratory problem	2	6.7	8	26.7		
d) Cataract	1	3.3	4	13.3		
e) Nil	0	0	0	0		
10. History of Taking medication for major illness						
a)Yes	6	20	19	63.3	0.545	0.460
b)No	2	6.7	3	10	(df=1)	NS

Table 4 .D.1. represents the association between pre-test level of depression with selected demographic variables with control group pre-test.

There was no association found between pretest level of depression with selected demographic variables in control group.

Table No 4.D.2 Association between pre- test level of depression and selected demographic data in experimental group .

(n=30)

Demographic Variables	Mild		Borderline		Moderate		$\chi 2$	p-value
	f	%	f	%	f	%		
1.Age in years								
a) 60-65	3	10	3	10	0	0		
b) 67-70	0	0	5	16.7	4	13.3	8.620	0.196
c) 71-75	4	13.3	2	6.7	4	13.3	(df=6)	NS
d) 76 - 80	2	6.7	2	6.7	1	3.3		
2. Gender								
a) Male	4	13.3	5	16.7	3	10	0.255	0.880
b) Female	5	16.7	7	23.3	6	20	(df=2)	NS
3.Religion:								
a) Hindu	2	6.7	5	16.7	4	13.3		
b) Christian	1	3.3	1	3.3	1	3.3	1.256	0.869
c) Muslim	6	20	6	20	6	13.3	(df=4)	NS
d) Others	-	-	-	-				
4.Education Status:								
a) Illiterate	1	3.3	3	10	1	3.3		
b) Primary Education	2	6.7	4	13.3	2	6.7	4.722	0.580
c) Secondary Education	5	16.7	2	6.7	5	16.7	(df=6)	NS
d) Higher Secondary	1	3.3	3	10	1	3.3		
5.Marital Status :								
a) Married	2	6.7	5	16.7	5	16.7	9.673	0.139
b) Unmarried	3	10	2	6.7	0	0	(df=6)	NS
c) Widow	2	6.7	5	16.7	4	13.3		
d) Divorced	2	6.7	0	0	0	0		

6.Source of Income :								
a) Pension	3	10	3	10	3	10	1.722	0.938
b) Government Aid	1	3.3	2	6.7	2	6.7	(df=6)	NS
c) Property	3	10	6	20	3	10		
d) Interest from Savings	2	6.7	1	3.3	1	3.3		
e) Others	-	-	-	-	-	-		
7.Number of Children:								
a) No Children	1	3.3	0	0	3	10	**12.994**	**0.044**
b) One	0	0	4	13.3	4	13.3	**(df=6)**	**S***
c) Two	6	20	4	13.3	1	3.3		
d) More than Two	2	6.7	4	13.3	1	3.3		
8.Duration Of Stay in Old Age Home:								
a) Less than 12 months	2	6.7	2	6.7	1	3.3	1.423 (df=4)	0.840 NS
b) 1-3 Years	4	13.3	4	13.3	5	16.7		
c) More than 3 Years	3	10	6	20	3	10		
9.Any medical illness:								
a) Diabetes mellitus	1	3.3	3	10	2	6.7	4.398 (df=3)	0.286 NS
b) Hypertension	4	13.3	2	6.7	3	10		
c) Respiratory Problem	2	6.7	6	20	2	6.7		
d) Cataract	2	6.7	1	3.3	2	6.7		
e) Nil	-	-	-	-	-	-		
10. History of Taking medication for major illness								
a)Yes	8	26.7	8	26.7	9	30	4.400 (df=2)	0.111 NS
b)No	1	3.3	4	13.3	0	0		

Table 4.D.2.represents the association between pre-test level of depression with selected demographic variables in experimental group.

There was no association found between level of depression with selected demographic variables ,except the number of children which alone shows association with the pre-test level of depression in experimental group

Discussion

CHAPTER – V

DISCUSSION

The present study was conducted to evaluate the effectiveness of Reiki on the level of depression among geriatrics. After the analysis and interpretation of the data obtained from the samples, the researcher found, there was a significant improvement on the level of depression among geriatrics.

The discussion about the study results are solely based on the objectives.

The first objective of the study was to assess the pretest & post test level of depression among geriatrics in control group and experimental group.

Regarding pretest and post- test level of depression in control group 3(10%) had borderline level of depression, and 27 (90%) had moderate level of depression in pre-test, whereas the same samples 3 (10%) had borderline level of depression, 27(90%) had moderate level of depression in post-test.

While seeing pre-test level of depression in experimental group 11(36.7%) had mild and19 (63.3%) had moderate level of depression. But in post- test 9 (30%) had borderline level of depression and 12 (40%) had mild level of depression and 9(30%) had moderate and no one had severe and extreme level of depression.

Hence it is inferred that the depression clients who underwent Reiki therapy and reduction in the level of depression from moderate and borderline to mild and borderline level of depression. A Study was conducted by **Vera E Potter** to evaluate the Reiki for depression the effectiveness of Reiki therapy in Depression. The research design used in this study was pretest\ posttest treatment and wait list control design.76 self selected participants from general population were selected. They were

randomly divided in to two groups. one was received Reiki therapy another group was not received. Zung Self – Rating Depression scale was used for measuring Depression. 82% of patients were reduced Depression and 18% of patients are still like that. The study concluded that Reiki therapy effective for treating Depression.

The second objective of this study is to assess the effectiveness of Reiki therapy among geriatrics by comparing post test scores between control and experimental group.

Based on the objective; the effectiveness of Reiki therapy on depression among geriatrics between control and experimental group was assessed by comparing post test scores using unpaired 't' test. The mean post-test score (23.33±4.52) was higher in control group than the mean post-test score (19.06±4.05)1 in experimental group among geriatrics. The mean difference in level of depression was 4.27. The obtained 't' value was 3.846 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing the level of depression in the experimental group and not in the control group. Hence the research hypothesis H1 is accepted.

The study findings was supported by a study conducted by **Richeson NE** to evaluate the effect of Reiki on Depression patients. 20 participants were randomly assigned to either an experimental or wait list control group. The pre and post -test measures by Beck Depression Inventory Scale. The research design included an experimental component to examine changes in these measures and a descriptive component [semi structured interview] to elicit information about the experience of having Reiki treatment. There was76% of reduction occur in experimental group and 24% have no changes. The study concluded that a significant differences were observed between the experimental and control groups on measurement.

The third objective of this study is to compare the pretest and post- test level of level of depression among geriatrics in experimental and control group. .

Based on the objectives; the effectiveness of Reiki therapy and depression among geriatrics between control and experimental group was assessed by comparing pre- test and post test scores using paired 't' test

The mean pretest level of depression score (22.50±4.07) was lower than the posttest on the level of depression score (19.06±4.05) among geriatrics. The mean difference in level of depression was 3.44. The obtained pre-test and post-test score of level of depression among geriatrics in experimental group revealed that 't' value was 3.28 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing depression level among geriatrics. Hence the research hypothesis H2 is accepted

The findings of my study was supported by a study conducted by **Shore and Adina** at Massey university, New Zealand for Long term effects of Reiki therapy on Depression.45 participants with symptoms of Depression volunteered for this study. Participants were randomly assigned to one of three groups; Hands on (touch) Reiki, Distance (non touch) Reiki, and Distance Reiki placebo. The study suggested that Reiki therapy have an significant reduction in Depression, participants were not received aware of which group would be receiving placebo Reiki.12 Reiki masters, and three second degree Reiki practitioners were chosen to conduct the one to one and one- half hour sessions. Each participant received one treatment weekly for 6 weeks. Three tests, designed to measure levels of Depression, were administered each participants before and after the series of 6 sessions.1 year later, the participants retook the three tests. After testing was completed, the control placebo group received another 6 weeks of Reiki treatments, this time with actual Reiki, and three test were

administered to this group again findings of the study demonstrated that there were no changes in the control\ placebo group until they received 6 session of actual Reiki a year after the first 6 placebo sessions. Both the hands on and the distance Reiki were effective in relieving symptoms of Depression. The study concluded that Reiki therapy have long term effects in reduction of Depression.

The fourth objective of this study is to find out the association between the pretest scores of depression with selected demographic variables among geriatrics in control group.

Regarding the association between pre-test score of depression in control group with selected demographic variables, there was no association found between pre-test level of depression with selected demographic variables in control group whereas number of children in the demographic variable alone is associated in experimental group. Hence the research hypothesis H4 is rejected.

The findings of my study was contrary to a study conducted by **Mansoureh Charkhandeh** conducted a study to investigate the effectiveness of two psychotherapeutic approaches, cognitive behavioral therapy (CBT) ad a complementary medicine method Reiki, in reducing depression scores in adolescents. We recruited 188 adolescent patients who were 12–17 years old. Participants were randomly assigned to CBT, Reiki or wait-list. Depression scores were assessed before and after the 32 week interventions or wait-list. CBT showed a significantly greater decrease in Child Depression Inventory (CDI) scores across treatment than both Reiki (p<.001) and the wait-list control (p<.001). Reiki also showed greater decreases in CDI scores across treatment relative to the wait-list control condition (p=.031). The analyses indicated a significant interaction between gender, condition and change in CDI scores, such that male participants showed a smaller treatment effect for Reiki

than did female participants. Both CBT and Reiki were effective in reducing the symptoms of depression over the treatment period, with effect for CBT greater than Reiki. These findings highlight the importance of early intervention for treatment of depression using both cognitive and complementary medicine approaches.

Summary and Recommendations

CHAPTER VI

SUMMARY AND RECOMMENDATIONS

A study is said to be incomplete, if it results are not communicated effectively to its users and consumers. This chapter outlines the present study approaches, major findings with inferences drawn from it, implication for nursing profession, limitations conclusion, and recommendations.

SUMMARY

The main focus of the present study was to evaluate the effectiveness of Reiki therapy on the level of depression among geriatrics in selected geriatric homes at Madurai.

The objectives of the study were

- To assess the pretest & post -test level of depression among geriatrics in control group and experimental group.
- To assess the effectiveness of Reiki therapy on depression among geriatrics by comparing post test scores between control and experimental group.
- To compare the pretest and post -test level of level of depression among in experimental and control group.
- To find out the association between the pretest scores of depression with selected demographic variables among geriatrics of control group.

Research Hypothesis

H_1-The mean post-test scores of control group is significantly higher than the mean post test scores of experimental group.

H_2-The mean pre-test score of is significantly higher than the mean post-test depression score of experimental group.

H_3-There is a statistically significant association between pre-test depression score with selected demographic variables in both control group.

ASSUMPTIONS

1. Geriatrics who are residing in geriatric home have depression.
2. Items in the questionnaire would be sufficient to assess the depression of thegeriatrics.
3. Responses of the geriatrics will be their true measures of depression
4. Reiki therapy will reduce the depression level of the geriatrics.

The extensive review of literature enabled the researcher to develop the conceptual framework, tool, methodology. Literature reviews as organized as follows

- General Information about Reiki.
- Literature related to depression in geriatrics.
- Literature related to geriatrics in old age home.
- Literature related to effectiveness of Reiki

The conceptual framework of this study was based on" modified J.W. Kenny's open system model". The research design selected for the study was quasi experimental research design with pretest post- test control group design. Independent variable in the study was Reiki therapy and dependent variable was level of depression among geriatrics.

The tool used in the study was Beck's depression inventory after confirming the validity and reliability . The reliability score obtained was r=0.87. The pilot study

was conducted among six geriatrics at Inba illam, Madurai. The study was found to be feasible, practicable, and reliable to continue the main study.

The main study was conducted in a geriatric home, at Christian Mission Hospital, Madurai. Simple random sampling technique was used to select the samples. Total sample size was 60 in which 30 in experimental group and 30 in control group. The objectives and purpose of the study were explained and confidentiality was maintained. Pre- test was done using the tool and the Reiki therapy was given for 14 days to the experimental group alone. After 14 days, post – test was done with same tool. After the data collection procedure Reiki therapy was given to the control group for ethical consideration. Data collected were analyzed and interpreted using descriptive and inferential statistics.

The findings of the study were

- In control group 3(10%) had borderline level of depression, and 27 (90%) had moderate level of depression in pre-test, whereas the same samples 3 (10%) had borderline level of depression, 27(90%) had moderate level of depression in post-test.
- While seeing pre-test level of depression in experimental group 11(36.7%) had mild and19 (63.3%) had moderate level of depression . But in post- test 9 (30%) had borderline level of depression and 12 (40%) had mild level of depression and 9(30%) had moderate and no one had severe and extreme level of depression.
- In control group 27 (90%) had moderate level of depression, 3 (10%) had borderline level of depression in pre-test, whereas a similar finding was seen in post test. While seeing pre-test level of depression in experimental group 19 (63.3%) had moderate 11 (36.7%) had borderline level of depression.

Whereas in post- test 12 (40%) had borderline level of depression and 9 (30%) had mild and moderate level of depression.

- The mean post-test score (23.33±4.52) was higher in control group than the mean post-test score (19.06±4.05)1 in experimental group among geriatrics. The mean difference in level of depression was 4.27. The obtained 't' value was 3.846 which showed a statistical significance at $p<0.001$ level. It was inferred that the Reiki therapy was significantly effective in reducing the level of depression in the experimental group and not in the control group.
- The mean pretest level of depression score (22.50±4.07) was lower than the posttest on the level of depression score (19.06±4.05) among geriatrics. The mean difference in level of depression was 3.44. Using the paired 't'test, the obtained pre-test and post-test score of level of depression among geriatrics in experimental group revealed that 't' value was 3.28 which showed a statistical significance at $p<0.001$ level.
- There was no association found between pretest level of depression with selected demographic variables in control and experimental group.

IMPLICATIONS

The results obtained from the present study proclaimed that, Reiki therapy will decrease the level of depression among elderly. The study also recommended the following implications in the nursing professional areas such as,

- Nursing practice
- Nursing education
- Nursing administration
- Nursing research

Nursing Practice

- The study findings revealed the importance of Nurse's role in managing depression among geriatrics by using Reiki therapy, which is cost-effective, safe and non-pharmacological treatment.
- In all old age homes, time should be allotted for Reiki therapy and sharing their past life experiences and ventilating their emotions and acceptance of their current situations, and getting out from the mental stress, along with their daily routine activity. Nurses specialized in psychiatry need to be empowered in providing Reiki therapy.
- Nursing administrator can enact legislation to monitor the welfare of organizations in providing security and quality care to elderly.

Nursing Education

- Reiki therapy can be included as a treatment for depression, in Nursing curriculum
- A considerable amount in the budget can be allocated for organizing the continuing Nursing education programme and training students to reduce depression among elderly.
- Professional conferences, workshop or seminar can be conducted on old age depression and significance of Reiki therapy in reducing depression.

Nursing Research

- The findings of the present study has added knowledge to the already existing literature and the implications for the nursing research are given in the form of recommendation.

- This study can be a base line for future studies to build upon and motivate other investigators to conduct further studies.

Nursing Administration

- The administrator can encourage the nurses to use different form of Reiki therapy which are cost effective, safe and psychotherapeutic intervention in reducing depression among geriatrics both in community and general wards.
- Nursing personnel working in old age homes and wards should be given in service education regarding significance of Reiki therapy in reducing depression.

CONCLUSION

Reiki therapy is a non-pharmacological psychosocial intervention for the treatment of depression. So in clinical practice, Reiki therapy can be used for all the clients.

RECOMMENDATIONS

On the basis of the present study the following recommendations have been made for further studies.

- A comparative study can be conducted between institutionalized and non-institutionalized geriatric with depression.
- A qualitative approach can be applied in studying the effects of Reiki therapy on depression.
- An experimental study on the effectiveness of Reiki therapy on depression among different age group.
- A comparative study can be conducted to evaluate the effectiveness of breathing exercise and Reiki therapy can be conducted among elderly.
- A comparative study can be conducted to evaluate the effectiveness of Reiki therapy can be conducted among geriatrics for larger samples.

References

REFERENCES

BOOKS

1. Birchwood M, Trower P, Brunet K, Gilbert P, Iqbal Z and Jackson C (2006) *Social anxiety and the shame of psychosis: a study in first episode psychosis.* Behaviour Research and Therapy, 45, 1025-1037
2. Birchwood, M., Iqbal, Z., Chadwick, P et al (2000) *Cognitive approach to depression and suicidal thinking in psychosis.* I: Ontogeny of post-psychotic depression. 177, 516-528
3. Bjelland, I. Dahl, A.A., Haug, T.T.& Neckelmann, D. (2002). *The validity of the Hospital Anxiety and Depression Scale:* An updated literature review, 52, 69-77.
4. Gerfo, M.L. 1980. Three Ways of Reiki in Theory and Practice. *The International Journal of Aging and Human Development*, 39-48.
5. Hayes, S. C. & Smith, S. (2005). *Get out of your mind and into your life:* The new Reiki Therapy.
6. Hill, Andrew; Brettle, Alison (1 December 2005).The effectiveness of counseling with older people: Results of a systematic review *Counseling and Psychotherapy Research* 5 (4): 265–272.
7. Iqbal, Z., Birchwood, M., Chadwick, P., et al (2000) *Cognitive approach to depression and suicidal thinking in psychosis:* 2. Testing the validity of a social ranking model. British Journal of Psychiatry, 177, 522-528.
8. Jacobson, N. S. & Truax, P. (1991) Clinical significance: *A statistical approach to defining meaningful change in psychotherapy research.* Journal of Consulting and ClinicalPsychology,12-19.

9. Jacobson, N. S., Foilette, W C., & Revenstorf, D. (1984). *Psychotherapy outcome research:* Methods for reporting variability and evaluating clinical significance. Behavior Therapy, 15, 336-352.
10. Lin, Y.C., Dai, Y.T., & Hwang, S.L. August, 2003. *The Effect of Reiki therapy on the Elderly Population:* A systematic Review. *Public Health Nursing.*20, (4), 297-306
11. Lin, Yen-Chun; Dai, Yu-Tzu; Hwang, Shiow-Li (1 July 2003).*The Effect of Reiki therapy on the Elderly Population:* A Systematic Review. *PublicHealth Nursing* 20(4): 297–306.
12. New Harbinger. Herman, C. (1997) *International experiences with the Hospital Anxiety and Depression Scale* – a review of validation data and clinical results. Journal of Psychosomatic Research, 42, 17- 41.
13. Petersen, C.L. (2007) *Treatment of comorbid depression and alcohol use disorders in an inpatient setting:* comparison of Reiki therapy versus treatment as usual.
14. Polit D.F.et.al 2003, *Nursing research principles and methods*, 3rd edition, J.B. Lippincott Company, Philadelphia,:30-35.
15. Radloff, L.S. (1977). The CES-D scale: *a self-report depression scale for research in the general population.* Applied Psychological Measurement 385–401.
16. Rocca, P., Bellino, S., Calvarese, P., Marchiaro, L., Patria, L., Rasetti, R., & Bogetto, F. (2005). *Depressive and negative symptoms in schizophrenia: different effects on clinical features.* Comprehensive Psychiatry, 304-310.

17. Sundar Rao P.S.et.al 1996.,An Introduction to biostatics,3rd edition, *Practice Hall of India Limited,* New Delhi,1996:98-106
18. Watt, L. M.; Cappeliez, P. (1 May 2000). *Integrative and instrumental commitment therapies for depression in older adults: Intervention strategies and treatment effectiveness. Aging & Mental Health* : 166–177.

JOURNALS

1. Alberta and Tsang KL *Department of Psychology, University of Calgary,* Integr Cancer Ther 2007.
2. Berardi D and Leggieri G ,Depression in P*rimary Care- as National Wide Epidemiological Survey* 2002, .397-400.
3. Bethesda MD, *Dept of Health and Human Services, National Institute of Mental Health ,U.S* 2001.
4. Murray C.J and Lopez A.D, *Global burden of disease study,* Lancet 2000,Page No.1498-1504.
5. Nandi D.N and Ajmany S, *The incidence of Mental Disorders in one year in a rural community in India,* Indian J Psychiatry 2006,Page No.79-87.
6. Nandi P.S and Banerjee G, *A Study of Psychiatric Morbidity of elderly population of rural community, Indian J Psychiatry* 2003,122-129.
7. Neauh N and Sonawalla S, *Screening for Major Depression in Asian Americans, A Comparison of the Beck and Chinese Depression Inventory,* AC-a Psychiar Scand 2002, .252-257.
8. Nguyen T and Flack C, *Third National Health and Nutritional Survey, Comparative prevalence of Depression by race / ethnicity,* Newyork 2004.

9. Nierenberg A.A, Fava M, *Illness Beliefs and Prevalence of Depressed American Patients,* J Nerv Ment Disc 2004, .324-327.
10. Ramachandhran V. Menon and Sarada M, Arunagiris Socio cultural factors in Depression, Indian J Psychiatry2002, 268-273.
11. Richeson NE and Spross Ja, *College of Nursing and Health Professionals, University of Southern Maine,* Portland, U.S.A 2010.
12. Sasikala G, *Nightingale Nursing Times,* Volume 6, September 2010, Page No. 34-36.
13. Sethi B.B, and Sharma M, *Depressive Disorders in the Developing World,* Int J Soc Psychiatry 2002..217-222.
14. Shore and Adina G, *Alternative Therapies in Health and Medicines* 2004, .42-48.
15. The WHO, *World Mental Health Consortium, Prevalence and Severity of depression,* 2006, .2581-2590.
16. Vera A. Poter Phd Holos *University Graduate Seminary, Reiki Effects on Depression.*
17. Wardell D and Engebreston J,*Biological Correlates of Reiki Touch Healing,* J Advanced Nursing2001, .439-445.
18. Zuleikha Ahmed, *Effectiveness of Reiki on Depression, Alternative Therapies in Health and Medicine,* October 2003.

NET

1. http:/www.ncbi.nlm.nih.gov/pubmed/19625067, www.pubmed.com
2. www.ncbi.nlm.nih.gov/pubmed/19688660, www.pubmed.com
3. http:/www.ncbi.nlm.nih.gov/pubmed/17158495, www.pubmed.com
4. http:/www.ncbi.nlm.nih.gov/pubmed/19747384, www.pubmed.com
5. http:/www.ncbi.nlm.nih.gov/pubmed/18940053, www.pubmed.com
6. http://EZIneArticles.com/?expert=Haroldcortez inJune2008.
7. http://www.happymoods.info\incidence and Depression –prevalence.
8. http://www.cureresearch.com/d/depression/ stas-Country.htm.
9. http://www.veraporter.com/research.htm/.

Appendices

APPENDIX-A

LETTER SEEKING EXPERTS OPINION FOR CONTENT VALIDITY

From

Mr. M. Andrew Solomon,
M.Sc(N) II Year,
Mental Health Nursing Dept,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Pasumalai.

To

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Forwarded Through
Prof. Dr.C.Jothi Sophia, M.Sc (N), Ph.D(N),
Principal,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Madurai.

Respected Sir/ Madam,

Sub: Requisition for content validity – reg

With due regards, I kindly bring to your valuable notice that, I am doing my post- graduation in Nursing at C.S.I Jeyaraj Annapackiam College of Nursing, Pasumalai, Madurai. I have selected the below mentioned topic for dissertation to be submitted to The TamilnaduDr.M.G.R. Medical University, Chennai as a partial fulfilment of Master of Science in Nursing.

"To evaluate the effectiveness of Reiki therapy on depression among geriatrics in selected old age homes at Madurai."

I have planned to do my study in your esteemed trust. So I humbly request you to give me to conduct the study for which I remain.

Thanking You

Place: Yours sincerely,
Date : (M.ANDREW SOLOMON)

APPENDIX-B

LETTER SEEKING PERMISSION TO CONDUCT PILOT STUDY

From

Mr. M. Andrew Solomon,
M.Sc(N) II Year,
Mental Health Nursing Dept,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Pasumalai.

To

The Secretary,
Inba illam;
Pasumalai,
Madurai-4

Forwarded Through
Prof. Dr.C.Jothi Sophia, M.Sc (N), Ph.D(N),
Principal,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Madurai.

Respected Sir/ Madam,

Sub: Requisition to conduct pilot study – reg

With due regards, I kindly bring to your valuable notice that, I am doing my post- graduation in Nursing at C.S.I Jeyaraj Annapackiam College of Nursing, Pasumalai, Madurai. I have selected the below mentioned topic for dissertation to be submitted to The TamilnaduDr.M.G.R. Medical University, Chennai as a partial fulfilment of Master of Science in Nursing.

"To evaluate the effectiveness of Reiki therapy on depression among geriatrics in selected old age homes at Madurai."

I have planned to do my study in your esteemed trust. So I humbly request you to give me to conduct the study for which I remain.

Thanking You

Place: Yours sincerely,

Date : (M.ANDREW SOLOMON)

APPENDIX-C

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

From

Mr. M. Andrew Solomon,
M.Sc(N) II Year,
Mental Health Nursing Dept,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Pasumalai.

To

The Secretary,
Christian Seva Trust
Alagappan nagar,
SMadurai-3

Forwarded Through
Prof. Dr.C.Jothi Sophia, M.Sc (N), Ph.D(N),
Principal,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Madurai.

Respected Sir/ Madam,

Sub: Requisition to conduct the study – reg

With due regards, I kindly bring to your valuable notice that, I am doing my post- graduation in Nursing at C.S.I Jeyaraj Annapackiam College of Nursing, Pasumalai, Madurai. I have selected the below mentioned topic for dissertation to be submitted to The Tamilnadu Dr.M.G.R. Medical University, Chennai as a partial fulfilment of Master of Science in Nursing.

"To evaluate the effectiveness of Reiki therapy on depression among geriatrics in selected old age homes at Madurai."

I have planned to do my study in your esteemed trust. So I humbly request you to give me to conduct the study for which I remain.

Thanking You

Place: **Yours sincerely,**

Date : **(M.ANDREW SOLOMON)**

APPENDIX-D

LETTER SEEKING PERMISSION TO CONDUCT RESEARCH STUDY

From

Mr. M. Andrew Solomon,
M.Sc(N) II Year,
Mental Health Nursing Dept,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Pasumalai.

To

The Medical Director
Christian Mission Hospital
Madurai-1

Forwarded Through

Prof. Dr.C.Jothi Sophia, M.Sc (N), Ph.D(N),
Principal,
C.S.I. JeyarajAnnapackiam College Of Nursing,
Madurai.

Respected Sir/ Madam,

Sub: Requisition to conduct the study – reg

With due regards, I kindly bring to your valuable notice that, I am doing my post- graduation in Nursing at C.S.I Jeyaraj Annapackiam College of Nursing, Pasumalai, Madurai. I have selected the below mentioned topic for dissertation to be submitted to The Tamilnadu Dr.M.G.R. Medical University, Chennai as a partial fulfilment of Master of Science in Nursing.

"To evaluate the effectiveness of Reiki therapy on depression among elderly in selected old age homes at Madurai."

I have planned to do my study in your esteemed trust. So I humbly request you to give me to conduct the study for which I remain.

Thanking You

Place: Yours sincerely,

Date : (M.ANDREW SOLOMON)

APPENDIX- E

LIST OF EXPERT

1) Dr. Arun Prasanna M.D.
Psychiatrist
Ramana Hospitals,
Madurai.

2) Prof. Dr. John sam arun prabu M.Sc(N),Ph.d
H.O.D of Community Health Nursing department, C.S.I Jeyaraj Annapackiam College of Nursing, Madurai

3) Mr. Suresh, M.Sc.
Clinical Psychologist,
Government Rajaji Hospital,
Madurai.

4) Prof. Dr. Mrs. Jaya Thanga Selvi, M.Sc(N), Ph.D, H.O.D of Medical Surgical Nursing Department, C.S.I Jeyaraj Annapackiam college of Nursing , Madurai.

5) Prof. Dr. Jessie Metilda M.sc (N) P.hd
H.O.D of Child health nursing
C.S.I Jeyaraj Annapackiam College of Nursing, Madurai.

6) Mrs. JoyChristy, M.Sc(N),
Asst. Professor,
Mental Health Nursing Department,
C.S.I. Jeyaraj Annapackiam College of Nursing

7) Prof.Dr.Rajamani, M.Sc(N), Ph.D.,
Mental Health Nursing Department, College of Nursing Government Rajaji Hospital, Madurai.

8) Mr. Ebenezer Devavaram M.Sc(N)
Forensic nurse
Central Mental Hospital,
Dublin,
Ireland

9) Mr. Mani M.Sc., M.Phil., Statistician.
Aravind Eye Hospital, Madurai.

10) Prof. Mr. Edwin Rajkumar M.A (Socio), MSW, Department of sociology,
C.S.I Jeyaraj Annapackiam College of Nursing, Madurai.

APPENDIX – F

QUESTIONNAIRE ON DEPRESSION AMONG GERIATRICS

SECTION – A

DEMOGRAPHIC VARIABLES

1.Age in years

a) 60-65 ☐
b) 67-70 ☐
c) 71-75 ☐
d)76 – 80 ☐

2. Gender

a) Male ☐
b) Female ☐

3.Religion:

a) Hindu ☐
b) Christian ☐
c) Muslim ☐
d) Others ☐

4. Educational Status

a) Illiterate ☐
b) Primary Education ☐
c) Secondary Education ☐
d) Higher Secondary ☐

5.Marital Status :

a) Married ☐
b) Unmarried ☐
c) Widow ☐
d) Separated or Divorced ☐

6.Source of Income :

a) Pension ☐
b) Government Aid ☐
c) Property ☐
d) Interest from Savings ☐
e) Others ☐

7.Number of Children:

a) No Children ☐
b) One ☐
c) Two ☐
d) More than Two ☐

8.Duration Of Stay in Old Age Home:

a) <1years ☐
b) 1-3 Years ☐
c) <More than 3 Years ☐

9.Any Medical illness :

a) Diabetes mellitus ☐
b) Hypertension ☐
c) Respiratory problem ☐
d) Cataract ☐
e) Nil ☐

10. History of Taking medication for major illness

a) Yes ☐
b) No ☐

SECTION – B

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1	0	I do not feel sad.
	1	I feel sad
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad and unhappy that I can't stand it.
2.		
	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel the future is hopeless and that things cannot improve.
3.		
	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4.		
	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5.		
	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.		
	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7.		
	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.		
	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.		
	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry the mout.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11. 0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look Unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appétit eat all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20	0	I am no more worried about my health than usual.
	1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
	2	I am very worried about physical problems and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think of anything else.
21		
	0	I have not noticed any recent change in my interest in sex.
	1	I am less interested in sex than I used to be.
	2	I have almost no interest in sex.
	3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score Levels of Depression

1-10These ups and downs are considered normal

11-16Mild mood disturbance

17-20Borderlineclinical depression

21-30Moderate depression

31-40Severedepression

over 40Extremedepression

பகுதி 1 : தனி நபர் விவரம்

இந்த பகுதியில் உள்ள உங்கள் சொந்த விபரங்களுக்கு சரியான விடை அளிக்குமாறு கேட்டு கொள்கிறேன்.

1. வயது

அ. 60-65 ☐

ஆ. 66-70 ☐

இ. 71-75 ☐

ஈ. 76-80 ☐

2. பாலினம்

அ. ஆண் ☐

ஆ. பெண் ☐

3. மதம்

அ. இந்து ☐

ஆ. கிறிஸ்தவர் ☐

இ. முஸ்லிம் ☐

ஈ. மற்றவை ☐

4. கல்வித் தகுதி

அ. படிக்காதவர் ☐

ஆ. தொடக்ககல்வி ☐

இ. நடுநிலைப் பள்ளி ☐

ஈ. பட்டதாரி ☐

5. திருமண தகுதி

அ. கல்யாணமாகதவர் ☐

ஆ. கல்யாணமானவர் ☐

இ. விவாகரத்து பெற்றவர் ☐

ஈ. விதவை ☐

6. பொருளாதார உதவி யாரிடமிருந்து வருகிறது

அ. ஓய்வூதியம் ☐

ஆ. அரசு உதவி பெறும் ☐

இ. சொத்து ☐

ஈ. வங்கி கணக்கு வட்டி ☐

7. குழந்தைகளின் எண்ணிக்கை

அ. குழந்தை இல்லை ☐

ஆ. ஒன்று ☐

இ. இரண்டு ☐

ஈ. இரண்டிற்கு மேல் ☐

8. எவ்வளவு காலமாக இங்கு உள்ளீர்கள்

அ. ஒராண்டுக்கு குறைவாக

ஆ. 1 – 3 ஆண்டுகள்

இ. 3 – 6 ஆண்டுகள்

ஈ. 6 ஆண்டுகளுக்கு மேல்

9. ஏதேனும் நோய்கள் உள்ளதா

அ. சர்க்கரை

ஆ. இரத்தக் கொதிப்பு

இ. சுவாச நோய்கள்

ஈ. கண் குறை

10. ஏதேனும் மருந்து எடுத்துக் கொண்டிருக்கிறீர்களா?

அ. ஆம்

ஆ. இல்லை

கீழே கொடுக்கப்பட்ட கேள்விகளிலிருந்து மனஅழுத்த அளவை சுய மதிப்பீட செய்ய இயலும்

1.

0 நான் கவலைப் படுகிறதில்லை

1 நான் கவலைப் படுகிறேன்

2 நான் எப்போதும் கவலைப்படுகிறேன் அதிலிருந்து என்னால் வெளிய வர முடிவதில்லை

3 நான் தாங்க முடியாத கவலையினதல் மகிழ்ச்சியற்று இருக்கின்றேன்.

2.

0 எனது எதிர்காலத்தைப் பற்றிய கவலை எனக்கில்லை

1 எனது எதிர்காலத்தைப் பற்றிக் கவலைகப்படுகிறேன்.

2 எனது எதிர்காலத்தைப் பற்றி ஒரு சிந்தனையும் எனக்கு இல்லை

3 எனது எதிர்காலம் நம்பிக்கையற்றதாகவும் முன்னேற்றம் இல்லாததுமாய்த் தெரிகிறது

3.

0 நான் தோற்றவனாக என்னை நினைக்கவில்லை

1 நான் சராசரி மனிதனை விட அதிகம் தோற்றிருக்கிறேன்

2 எனது வாழ்க்கையைத் திரும்பிப் பார்க்கும் போது நிறைய தோல்விகளை சந்தித்திருக்கிறேன்.

3. நான் முழுமையான தோல்வி நிறைந்த மனிதனாக என்னை நினைக்கிறேன்.

4.

0 எனக்குப் (வழக்கமான) காரியங்களில் நான் திருப்தி அடைகிறேன்.

1 என் வழக்கமான காரியங்களில் நான் பெருமகிழ்ச்சி அடைகிறதில்லை

2 எப்போதும், எந்த விஷயங்களிலும் எனக்கு திருப்தி கிடைக்கிறதில்லை

3 எல்லா விஷயங்களிலும் எனக்கு அதிருப்தியும் சலிப்புமாய் இருக்கிறது

5

0 குற்றஉணர்வு எதுவும் எனக்கு இல்லை

1 குற்ற உணர்ச்சி எனக்குச் சரியாகத் தெரிகிறது

2 நான் பெரும்பாலும் குற்ற உணர்ச்சி உள்ளவனாக நினைக்கிறேன்

3 நான் எப்போதும் குற்ற உணர்வு உள்ளவனாக என்னை நினைக்கின்றேன்.

6

0 நான் தண்டிக்கப்பட வேண்டியவனில்லை என நினைக்கின்றேன்

1 நான் தண்டிக்கப்பட வேண்டும் என நினைக்கிறேன்

2 நான் தண்டிக்கப்பட வேண்டும் என எதிர்பார்க்கிறேன்

3 நான் தண்டிக்கப்பட்டுக் கொண்டிருப்பதாக நினைகின்றேன்.

7

0 என் சுயத்தில் ஏமாற்றமடைந்தவனாக நான் நினைக்கவில்லை

1 நான் அதிருப்தியோடு இருக்கிறேன்

2 என்னைப் பற்றி நான் கசப்பாக நினைக்கிறேன்

3 நான் என்னை வெறுக்கிறேன்.

8

0 யாருடனும் தாழ்வடைந்தவனாக என்னை நினைக்கவில்லை

1 என் பலவீனங்களையும் என் தவறுகளையும் மோசமாக, சிக்கலுள்ளதாக நினைக்கிறேன்

2 என்னை நானே குற்றப்படுத்துகிறவனாக நினைக்கின்றேன்

3 எல்லா கெட்ட நடப்புகளிலும் என்னைச் சம்மந்தப்படுத்தி குற்றப்படுத்துகிறேன்.

9.

0 தற்கொலைக்குரிய எந்த எண்ணமும் எனக்கு இல்லை

1 தற்கொலைக்குரிய எண்ணமும் இல்லை. அதை முயறச்சிக்கவும் இல்லை

2 தற்கொலை செய்துக் கொள்ள விரும்புகிறேன்.

3 சில சந்தர்ப்பம் வாய்த்தால் நான் தற்கொலை செய்துகொள்வேன்

10

0 பெரும்பாலும் தேவையில்லாமல் அழுவதில்லை

1 தேவைக்கும் மேல் அழுகிறேன்.

2 எல்லா நேரங்களிலும் நான் அழுகிறேன்

3 முன்பு காரணத்தோடு அழுவேன் இப்போது அழ வேண்டும் என நினைத்தாலும் நான் அழ முடியவில்லை

11

0 நான் எந்த சூழ்நிலையிலும் எரிச்சலடைவதில்லை

1 இப்போது வழக்கமாக இருப்பதை விட எரிச்சலடைகிறேன்

2 நான் பெரும்பாலும் எரிச்சலுடன் இருக்கிறேன்

3 எல்லா நேரத்திலும் எரிச்சலுடையவனாக இருக்கிறேன்.

12

0 மற்றவரைக்குறித்த சிந்தனைகள் இல்லாமல் இல்லை

1 மற்ற மக்களைக்குறித்து இருக்க வேண்டிய சிந்தனை என்னிடம் இல்லை

2 மற்றவரைக்குறித்த எந்த சிந்தனையும் எனக்கு இல்லை

3 மற்றவரைக்குறித்த சிந்தனையற்று இருக்கின்றேன்.

13

0 என்னைக்குறித்து எப்போதும் திட்டமிட்டுக் கொண்டிருக்கிறேன்.

1 என்னைக்குறித்த திட்டம் எதுவும் எனக்கில்லை

2 சரியான முடிவெடுத்தலில் எனக்கு பிரச்சனை உள்ளது

3 சரியான முடிவெடுத்தலில் எப்போதும் பிரச்சனையோடு இருக்கிறேன்.

14

0 நான் மோசமானவன் என நிலைக்கவில்லை

1 நான் அழகற்றவனாகவும கவர்ச்சியற்றவனாகவும் இருக்கின்றேன் என கவலையடைகிறேன்.

2 நிரந்தரமாகவே எனது தோற்றம் அழகற்றதாக இருக்கிறது என நான் நினைக்கின்றேன்.

3 நான் அழகற்றவன் என்பதை நம்புகிறேன்.

15

0 எப்போதும் போல் என்னால் உழைக்க முடியும்

1 உழைக்க முற்படுவதற்கு நிறைய கடினங்கள் உண்டு

2 உழைப்பதற்கு எனக்கு நானே கடினமாக முயலுகிறேன்.

3 என்னால் எந்த உழைப்பும் செய்ய இயலாது

16

0 எப்போதும் போல நான் தூங்குகிறேன்

1 எப்போதும் போல என்னால் தூங்கமுடியவில்லை

2 ஒரு சில மணி நேரங்களுக்கு முன்னதாக எழுந்து விடுகிறேன் மறுபடியும் தூக்கத்திற்கு செல்லமுடியவில்லை

3 நான் பலமணி நேரங்களுக்கு முன்னதாக எழுந்து விடுகிறேன் மேலும் மறுபடியும் என்னால் தூங்க முடியாது

17

0 நான் எப்போதும் களைப்படைவதில்லை

1 வழக்கானதைவிட நான் விரைவில் களைப்படைகிறேன்

2 என்ன வேலை செய்தாலும் நான் களைப்படைகிறேன்

3 எப்போதும் மிகவும் நான் களைப்புள்ளவனாக இருக்கிறேன்.

18

0 எனக்கு அதிகம் பசிப்பதில்லை

1 எனக்கு நிறைய பசிக்கிறது

2 இப்போது மிகவும் அதிகமாக பசிக்கிறது

3 எப்போதும் எனக்கு பசிக்கவே இல்லை

19

0 எனது எடை குறைவதில்லை

1 5 கிலோவுக்கு மேலாக எனது எடை குறைந்துள்ளது

2 10 கிலோவுக்கு மேலாக எனது எடை குறைந்துள்ளது

3 15 கிலோவுக்கு மேலாக எனது எடை குறைந்துள்ளது

20

0 எனது சுகத்தைப் பற்றி நான் கவலைப் படுவதில்லை.

1 எனத உடல்நிலையில் உள்ளவலிகள் வயிற்று உபாதைகள், உடம்பு வலி, மலச்சிக்கல் இவற்றைப் பற்றி கவலைப்படுகிறேன்.

2 எனது உடல்நிலையில் உள்ள சுகவீனங்களைக் குறித்து மிகவும் கவலைப்படுகிறேன்.

3 எனது உடல் சுகவீனத்தைச் பற்றிய சிந்தனையுடனே நான் எப்போதும் இருக்கிறேன்.

21

0 பாலுறவினைக்குறித்த மாற்றங்கள் குறித்து இப்போது நான் நினைப்பதில்லை

1 வழக்கமான விருப்பத்தினை விட இப்போது பாலுறவில் விருப்பம் குறைந்துள்ளது

2 பாலுறவில் எனக்கு பெரும்பாலும் விருப்பம் இருப்பதில்லை

3 பாலுறவைக்குறித்த விருப்பம் எனக்கு இப்போது முற்றிலும் இல்லை

கொடுக்கப்பட்ட கேள்விகளின் மதிப்பெண்களை வலதுபுறத்தில் நீங்கள் குறித்த விடைகளிலிருந்து கணக்கிடுங்கள். இந்த முழுமையான சோதனைக்குரிய அதிகபட்ச மதிப்பெண் 63. நீங்கள் குறித்து கொடுத்த 3வது விடைகளுக்குரிய மதிப்பெண்களின் மொத்தம் இதுவாகும் குறைந்தபட்ச மதிப்பெண் 0 நீங்கள் ஒவ்வொரு வினாவிற்குரிய முதல் விடையைக் குறித்திருந்தால் அது 0 வாக இருக்கும் உங்கள் மன அழுத்தத்தைக் கீழ்கண்ட அட்டவணையின் மூலம் மதிப்பிடலாம்.

மொத்த மதிப்பெண்கள் _____ மன அழுத்தத்தின் அளவுகள்.

1-10 _____மன அழுத்தநிலை சாதாரணமாக உள்ளது

11-16 _____ மன அழுத்தம் சற்று தடுமாற்றத்துடன் உள்ளது

17-20 _____மன அழுத்த நோய் வரம்பிற்குள் உள்ளது

21-30 _____மன அழுத்த நோய் உள்ளது

31-40 _____தீவிரமான மன அழுத்தம்

> 40 _____அதிக மன அழுத்த நோய் உள்ளது.

APPENDIX – G

CERTIFICATE OF BASIC COUNSELLING SKILLS AND TOUCH THERAPY

THE VALLIAMMAL INSTITUTION (TVI)

2/18A Upstairs, B.B. Road 2nd St., Pankajam Colony , Madurai-625 009.

✆ 98942 49630; 98430 40226 email: ananthibetsy@rediffmail.com

Reg. No. PCC/51/Nov. 16/318 Date: 28/11/16

Certificate Course in Basic Counselling Skills and Touch Therapy

This is to certify that M. ANDREW SOLOMON *.... has completed our* **CERTIFICATE COURSE IN BASIC COUNSELLING SKILLS AND TOUCH THERAPY** *(24hrs Part-time Education Programme designed and offered by experts) by effectively participating in theory & practical classes and successfully completing all the exercises. He has been placed in First Class*

Prof. Dr. S. Jeyapragasam M.Sc.,M.A.,M.A.,Ph.D.,
Director
Rajarajan Institute of Science (RISE)

Dr. B. Ananthavalli M.Sc.,M.A.,M.Phil.,Ph.D.,
Director & Secretary
The Valliammal Institution (TVI)

LESSON PLAN

ON

REIKI THERAPY

APPENDIX -H

TEACHING ON REIKI THERAPY FOR DEPRESSION THERAPY

Teachers name	:	M. Andrew Solomon
Subject	:	Psychiatric Nursing.
Topics	:	Teaching on Reiki therapy for depression.
Group	:	Geriatrics.
Duration	:	1 Hour.
Method of teaching	:	Lecture Cum Discussion.
AV-AIDS	:	Power Point

CENTRAL OBJECTIVES

At the end of the educational program the geriatrics will be able to gain in depth knowledge on Reiki therapy, develop awareness regarding depression and implement the Reiki therapy in their day today life during periods of depression.

CONTRIBUTORY OBJECTIVES

At the end of teaching the patients will be able to

-define Reiki therapy.

-list down the health benefits of Reiki therapy.

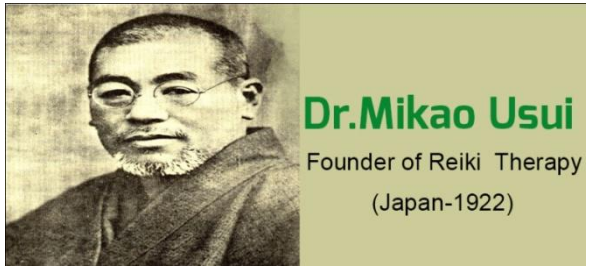
-enumerate the need of Reiki for depression

-explain about the dangers of depression

-discuss about the benefits of Reiki therapy for depressed clients.

-discuss about Reiki positions for depression.

-discuss about the relevant research regarding Reiki therapy for depression.

TIME	SPECIFIC OBJECTIVE	CONTENT	TEACHING ACTIVITY	LEARNING ACTIVITY	EVALUATION
3MIN	The group will be able to understand about the introduction regarding Reiki therapy	Reiki is a form of alternative medicine developed in 1922 by Japanese Buddhist **MikaoUsui**. Since originating in Japan, Reiki has been adapted into varying cultural traditions across the world. Reiki practitioners use a technique called *palm healing* or *hands-on healing* through which a "universal energy" is allegedly transferred through the palms of the practitioner to the patient in order to encourage emotional or physical healing. Reiki is pseudoscience. It is based on *qi* ("chi"), which practitioners say is a universal life force, although there is no empirical evidence that such a life force exists. Reiki is increasingly offered in hospital, hospice, and private practice settings, applied to a variety of illnesses and conditions. Those who receive such treatments report relief of symptoms from numerous health challenges, including mental health issues 	POWERPOINT PRESENTATION	LISTENING	

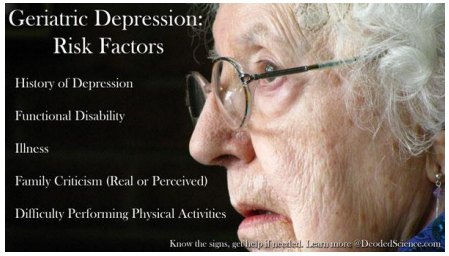
3MIN	The group will be able to define Reiki therapy	**DEFINITION** • Reiki is a therapy often described as palm healing or hands-on-body healing in which a practitioner places hands lightly on or over a patient's body to facilitate the patient's process of healing. • Reiki combines the Japanese and Chinese word-characters of "rei" (spiritual or supernatural) and "ki" (vital energy). One of the basic ideas held by those who practice Reiki is that this vital energy can be channeled to support the body's natural ability to heal itself, according to the National Center for Complementary and Integrative Health (NCCIH).	POWERPOINT PRESENTATION	LISTENING	Define Reiki therapy

	The group will be able to explain the health benefits of Reiki therapy.	**BENEFITS OF REIKI THERAPY** ➢ **HEALTH BENEFITS** • One of the greatest Reiki healing health benefits is stress reduction and relaxation, which triggers the body's natural healing abilities (immune system), aids in better sleep and improves and maintains health. • Reiki helps bring about inner peace and harmony. It can be valuable tool in the quest for spiritual growth • Reiki also balances the mind and emotions. Regular Reiki treatments can bring about a calmer and more peaceful state of being, in which a person is better able to cope with everyday stress. This mental balance also enhances learning, memory and mental clarity. Reiki can heal mental/emotional wounds, work through dysfunction In more severe situations, Reiki can help	POWERPOINT PRESENTATION	LISTENING	What are all the health benefits of Reiki therapy

3MIN		alleviate mood swings, fear, frustration and even anger. Reiki can also strengthen and heal personal relationships. Because Reiki enhances your capability to love, it can open you up to the people around you and help your relationships grow. By improving your capacity for empathy, Reiki allows you to connect with people on a deeper level. • Reiki offers relief during emotional distress and sorrow. Reiki helps in the grieving process. It cleans and clears the emotions, preventing them from being so draining and offers perspective. • On the physical level, Reiki helps to relieve pain from migraine, arthritis, sciatica ~ just to name a few. It also helps with symptoms of asthma, chronic fatigue, menopausal symptoms, and insomnia.	POWERPOINT PRESENTATION	LISTENING	

		• Reiki speeds up recovery from surgery or long-term illness. As it helps in adjusting to medicine/treatment, it also tends to reduce side-effects. For example, Chemo-therapy patients who received Reiki noticed a marked decrease in side effects from treatment. • Reiki can be an effective way to treat immediate problems, such as physical or mental illness (recovery from surgery, but regular treatments can also improve overall health. By helping to maintain a state of physical and emotional balance, Reiki can not only treat problems, but perhaps even prevent them from ever developing. **REIKI FOR DEPRESSION** According to the World Health Organization, depression affects approximately 400 million people around the world. When it isn't properly treated, this condition reduces quality	POWERPOINT PRESENTATION	LISTENING	

	The group will be able to discuss about the dangers of depression.	of life for sufferers and can lead to a number of serious consequences. Many different treatments exist for depression. However, regardless of the treatment methods chosen, patients dealing with the symptoms of depression may experience benefit from participating in Reiki sessions in conjunction with their professional treatment programs and methods. **The Dangers of Depression** Depression is a common condition that causes affected individuals to experience feelings of sadness, guilt, loss of interest in enjoyable activities, appetite disturbances, low self-esteem and sleep issues. It can affect people regardless of age, gender, ethnicity, occupation or any other characteristic. Although depression may occur after someone experiences a trauma, such as a death in the family, loss of a job or a serious illness, it can also appear to occur without an apparent cause.	POWERPOINT PRESENTATION	LISTENING	What are all the dangers of depression

		If left untreated, depression can affect the sufferer's quality of life, as well as his or her personal relationships. Depression can also affect the individual's professional life by impairing his or her ability to function while at work. In the worst cases, depression may even result in total disability or death by suicide. Because it can be so serious, finding effective treatment for depression is essential. So, seeking a qualified professional skilled in therapy, treatment programs, and talking with your physician is the first course of action. Then, in conjunction with working with a professional team and or program, Reiki can help as an adjunct therapy.  	POWERPOINT PRESENTATION	LISTENING	

3MIN	The group will be able to list down the benefits of Reiki therapy for depressed clien	  **Benefits of Reiki for Depressed Clients** Reiki can be beneficial to clients with depression in multiple ways. Some of the benefits of Reiki sessions for depressed clients include: • **Better sense of mental and physical balance.** – Reiki may help restore a person's overall sense of balance, both in the mind and the body. This may help to improve the person's mood and help him or her to overcome feelings of guilt and/or sadness. • **Reiki is relaxing.** – Depression is often accompanied by anxiety. However, Reiki can be relaxing, which may	POWERPOINT PRESENTATION	LISTENING	List down the benefits of Reiki for depressed clients.

		help to combat this anxiety. As the individual's anxiety is relieved, his or her depression may improve as well. • **Reiki puts the client back in control.** – Many people who are depressed feel like they are not in control of their own lives. When a client participates in a Reikisession, he or she is doing something proactive, thus restoring some of the feelings of control. • **Reiki allows the client to connect with another person. –** One of the most common symptoms of depression involves withdrawing from friends and family or feeling disconnected from others. Reiki provides depressed clients with the opportunity to connect with a caring, compassionate practitioner, which may improve symptoms. • **Reiki relieves stress. –** Stress can contribute to the development of depression, and ongoing stress can also	POWERPOINTPRESENTATION	LISTENING	

3MIN	The group members will be able to enumerate the positions and steps of procedure for doing Reiki therapy among depressed geriatrics	worsen a depressed person's symptoms. Reiki may help to relieve some of a client's stress, which may in turn reduce the symptoms of depression. **REIKI POSITIONS FOR DEPRESSION** You can learn the Reiki hand positions for self and treating others. These Reiki positions are very helpful to relieve mental depression. In these positions the hands are placed on energy centers of the body. Due to the fact that endocrine system is influenced by these energy centers, when Reiki is given to the energy centers there is a balancing effect on the glands. When secretion by the glands is balanced, the body comes back into its natural healthy state. • Place hands on the back of the head and give Reiki. This will promote relaxation and get rid of headaches associated with depression.	POWERPOINT PRESENTATION	LISTENING	Can you enumerate the positions and steps of procedure for doing Reiki therapy among depressed geriatrics?

3MIN		• Gastrointestinal problems are often associated with depression. The gastrointestinal problems may include nausea, vomiting, stomach ache and indigestion. For these problems you can place your hands on the either sides of the navel or umbilicus and slightly to one side. Relief from these symptoms improves the health condition and helps to decrease the level of depression. • For another specific symptoms of depression like muscle ache and headache, place hands across the shoulder blades (scapulae) at mid to upper point. This position will help you to get rid from muscle ache, head ache and also from the stomach ache. • You can also place your hands across the lower ribs. This position impacts the kidneys. This position will improve the function of the adrenalin glands and ultimately change the mood to positive.	POWERPOINT PRESENTATION	LISTENING	

		     	POWERPOINT PRESENTATIO	LISTENING	

3 MIN		**Relevant Research** Several research studies support the use of Reiki for people with depression. Some of these studies are listed below. 1. **Reiki aids in relaxation.** – *Center for Reiki Research* According to the Center for Reiki Research, Reiki has been shown to reduce sympathetic autonomic stimulation and produce a significant relaxation response among people who had been diagnosed with Burnout Syndrome, a disorder characterized by exhaustion and emotional issues. It is likely that the same relaxation response would be produced among clients with depression. 2. **Reiki reduces the symptoms of depression.** – *Alternate Therapies in Health and Medicine* In addition, according to a study published in Alternate	POWERPOINT PRESENTATIO	LISTENING	

		Therapies in Health and Medicine, patients who received regular Reiki treatments demonstrated a significant reduction in the symptoms of psychological distress and depression. The symptom reduction experienced by these patients continued for one year after the treatment regimen was complete. **3. Reiki may reduce postoperative depression.** – *Anecdotal Evidence* Furthermore, anecdotal reports by trained Reiki healer Julie Motz indicate that Reiki can effectively reduce postoperative depression among heart transplant patients. **CONCLUSION** Overall Reiki therapy is an inexpensive and potentially beneficial approach to helping the elderly age successfully and happily. It appears to provide them with a sense of overall life satisfaction and coping skills and may also help to a me.	POWERPOINTPRESENTATIO	LISTENING	